Health Care Reform at the State and National Level

# Partisanship, Dysfunction, and Racial Fears: The New Normal in Health Care Policy?

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**Abstract** Partisan politics snarled both the passage and the implementation of the Affordable Care Act (ACA). This essay examines partisanship's effects on health policy and asks whether the ACA experience was an exception or the new political normal. Partisanship itself has been essential for American democracy, but American institutions were not designed to handle its current form—ideologically pure, racially sorted, closely matched parties playing by "Gingrich rules" before a partisan media. The new partisanship injects three far-reaching changes into national health policy: an unprecedented lack of closure, a decline in the traditional political arts of compromise and bargaining, and a failure to define and debate alternative health policies. We can get a better sense of how far partisanship reaches by turning to state health policies. The highly charged national debate has migrated into some of the states; others retain the traditional politics of compromise and problem solving. There are preliminary indications that the difference lies in the dynamics of race and ethnicity.

**Keywords** Affordable Care Act (ACA), partisanship, race

> *Let me warn you in the most solemn manner against the baneful effects of the spirit of party. . . . The disorders and miseries which result . . . always distract the public councils and enfeeble the public administration.*
> —George Washington, "Farewell Address," September 1796

> *If we are able to stop Obama on this, it will be his Waterloo. It will break him.*
> —Senator Jim DeMint, July 2009

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Partisanship is rising in the United States. Congress is more deadlocked than it has been for a century. Deep divisions split the parties, spill into state governments, roil the engaged public, and perhaps (for this is disputed) split the general population (Abramowitz and Fiorina 2013; McAdam and Kloos 2014: chap 1; Mansbridge and Martin 2013). Party affiliation now trumps race, class, and gender in predicting political views and values (Pew Research Center 2012). The consequences appear to echo George Washington's (1997: 968–69) warning about partisan politics: disordered government and feeble public administration.

Party conflict appears especially sharp in health care policy. The battle over the Affordable Care Act (the ACA or Obamacare) is an extreme instance of partisan politics. The legislation passed in 2010 with just one Republican vote in the House and none in the Senate; Republicans took the conflict to the Supreme Court, which narrowly upheld one central provision (the mandate to buy insurance) and sent the authority over another (Medicaid expansion) to state capitals, where the debate continues (*National Federation of Independent Business v. Sebelius*, 567 U.S. ___, 132 S.Ct. 2566 (2012)). The fight persisted through the elections of 2012 and 2016, bounced back through the courts (with *King v. Burwell*, 576 U.S. ___ (2015)), profoundly disrupted the implementation of the program, and continues to blow up in the Republican Congress (which shuttered the government, voted repeal more than fifty times, and continues to harry the program) (Pear 2015). Six years after passage, the debate goes on in Congress, courts, and state capitals and on the hustings.

There are almost no precedents in American history for such sustained conflict. While court decisions have set off great national debates, acts of Congress normally settle the issue. The political conflict sparked by the ACA makes health care policy less stable, less predictable, and less effective. In this essay, I ask whether the sustained conflict over the ACA illustrates a new normal for health care policy. Or was it an exceptional case—perhaps complicated by both conservative activism and a backlash against the first black president? I suggest that the United States is poised between these two alternatives—between the new partisanship and a more traditional, pragmatic health policy debate. In the long run, the difference may lie in how American politics—on both the national and the state level—negotiates the emergence of a majority-minority population.

In this essay, I anchor our contemporary division by reviewing the rise of American partisanship. Robust party debate is indispensable for democracy, but our political system was not designed to handle the kind of conflict we see today. Next I explain what is new about contemporary partisanship.

I then examine how partisan conflict shapes health care policy. In some ways, the long, loud debate—right down to cries of "socialism"—stretches back seven decades to the Truman administration. In other ways, however, health politics in the Barack Obama years break with the past. The key to weighing continuity versus change lies in the states where governments teeter between the strong partisanship of national politics and traditional interest-group pragmatism. I suggest that the balance between the partisanship and pragmatism may be motivated by the politics of race and immigration.

David Mechanic developed a concept that offers some purchase in diagnosing the current state of health care politics: the idea of *trust*. In Mechanic's (1998: 661) formulation, trust is "the expectation that institutions and professionals will act in one's interests." Mechanic used the concept to explore the tension between professional norms and market forces. The same concept can be applied to governing institutions. Politicians and activists have lost trust in the other party. On the most fundamental level, the parties differ in their trust of government. Democrats are more likely to trust experts and public officials; Republicans trust markets. And Americans generally trust state government more than federal—at least until race and immigration enter the equation.

When issues grow racialized, however, an entirely different framing offers more purchase: moral politics. Immigrant and black communities stir up ancient American fears—of immoral practices and strange (un-American, unacceptable) values that threaten a good society. Historically, the fears and stereotypes are especially powerful in public health politics (Morone 1997, 2003). Contemporary parties mobilize the issue because, for the first time, one party draws the full range of minority groups and the other appeals largely to white Americans. The result appears to yield very different health policy choices in different states.

## The Roots of Partisan Politics

Both the United States and Europe are grappling with what political scientist Ira Katznelson describes as an existential crisis in legislative government. The American House and Senate, he writes, are so "paralyzed by party divisions, [they] . . . appear unable to identify and address our most consequential public problems" (Katznelson 2015: 14). Partisanship gives voters a meaningful choice, but the American system was not engineered for intense partisan politics. How do we balance meaningful choice without undermining the ability to govern?

## The Two Faces of Partisan Politics

We get no help if we look back to the Constitution. The founders did not agree on many things, but they were unanimous in rejecting political parties. Benjamin Franklin was so worried about them that he urged the Constitutional Convention to forbid salaries to public officials—the money, he thought, would generate political competition. Washington (1997) spent much of his 1796 "Farewell Address" pleading with Americans to end the party strife that had already torn up his cabinet and threatened, in his view, the entire republican experiment. James Madison (1788: 1), the most sophisticated of the first-generation thinkers, called contesting factions "the mortal diseases under which popular governments have everywhere perished." And Thomas Jefferson (1984: 942–43), as usual, managed the most quotable summation, in 1789: "If I could not go to heaven but with a party, I would not go there at all." Political parties were the only major feature of American governance that was not debated at the Constitutional Convention or among the founding generation. As a result, there is no early conceptual map about their proper role.

Although party competition sprang up almost immediately, it took American leaders almost a half century to fully embrace it. When they finally did so, in the 1820s, they illustrated the enduring conundrum of partisanship by identifying two very different dimensions (Hofstadter 1969).

On the one hand, the parties were and are the great American engines of democracy. They gave the (white, male) people an unprecedented say over the choices facing the new nation. From the very start, Americans disagreed about whether they wanted an active, ambitious national government (championed by Washington, Hamilton, and John Adams) or a small and retiring one that deferred to states and individuals (Jefferson, Madison). Factions immediately sprang up around the question. As the factions grew into parties, they became the largest and most sophisticated organizations in the early republic. As they maneuvered for advantage, the parties pushed the franchise to more and more (white, male) voters. Mass political parties championed democracy, offered the voters choices, and became one of the most enduring American contributions to popular government.

As the political parties developed, they became loose coalitions holding together many attitudes. Political scientists repeatedly criticized them for not offering a clear enough choice between competing visions of government. Woodrow Wilson made the case in his classic text *Congressional Government* (1885), and the American Political Science Association picked up the call in 1950 (APSA 1950). Be careful what you wish for: on

this dimension—a clear choice between governing philosophies—the political parties are stronger than they have been since the Civil War. Americans genuinely differ on whether government should play a role in ensuring access to health care. Democrats overwhelmingly say "yes" (83 percent); Republicans do not (only 34 percent agree) (Pew Research Center 2015). Today's political parties give the public a clear choice that echoes the first generation's debate about strong national government.

On the other hand, the original party leaders crudely grasped for power. Their organizations were petty, partisan, and focused on plunder. Followers were expected to toe the party line and support the party's candidates without question or independent thought. Senator William Marcy (D-NY) famously explained the whole point of the electoral contest, in 1832, when he noted, approvingly, that "politicians . . . preach what they practice. . . . They see nothing wrong in the rule that to the victor belong the spoils [of government]" (quoted in Morone 1998: 85–86). The parties' aspiration to democracy always came tied to the grubby press for advantage. It tainted the legacy of parties, partisans, and power politics. Contemporary parties offer an unusually clear choice between governing philosophies and, at the same time, an especially naked politics of power that threatens the good working order of American governance.

## The Leap out of Politics

The ambivalence about party politics runs from the founding fathers through American history—and right into health care policy. Each party, in its own way, yearns to leap out of partisan politics. Democrats (reflecting Washington, the original Federalists, and Progressives through the ages) defer to experts. For example, best practices ought to guide health care delivery. Economists, health services researchers, and carefully designed studies can best inform practitioners, organize incentives, and allocate resources. The Democrats tend to trust—precisely in Mechanic's sense of the term—the expert, the public official, and even the bureaucrat.

Across the party divide, the Republicans also dream of leaping out of politics. They push to get government out of health care altogether. The markets—the sum of individual choices—ought to guide health care decisions. They would repeal as many programs as possible (Obamacare!) and discipline (or modernize) popular government programs like Medicare with as much competition as the political market will bear.

At bottom, Democrats and Republicans trust (and distrust) entirely different institutions. Republicans, implicitly invoking Senator Marcy and

the grubby side of politics, finger every Democratic proposal as bureaucrats run amok and offer the freedom of individual choice in return (Blumenthal and Morone 2009). Democrats respond that the markets are great engines of inequality and injustice (Marmor 2007).

The choice in values has never been more clarified. However, as Americans from Presidents Washington to Obama have painfully learned, there is no getting out of the grubby politics. For better and for worse, our health care policies will be deliberated, chosen, implemented, and administered in the great American partisan scrum. Those politics have never been louder or more disruptive than they are today.

## Partisanship Today

Political scientists know a great deal about partisanship in Congress but less about how it has spilled into state government or how it has touched racial and ethnic divisions—though all three fault lines carry major implications for health policy (Tesler 2012; Mansbridge and Martin 2013). In Congress, polarization has been rising since around 1978—a conclusion that rules out plenty of conventional wisdom: that the conflict erupted during the disputed election of 2000, or the Bush administration (2001–9), or the Obama administration (2009–17) or with the sudden rise of the Tea Party (2010) or with the extreme gerrymanders that appear to have locked in a Republican House (but do not touch the Senate). While each may reflect the rising polarization, none is the underlying cause.

### Five Reasons for Rising Partisanship

What does explain the rise and spread of partisanship? There are five major reasons.

*The Party Sort.* Through most of the twentieth century, both parties included strong liberal and conservative factions. The Republican Party stretched from John Birch Society members on the right to urban liberals battling the big city machines. The Democratic Party divided into southern conservatives and northern liberals—Katznelson tagged the midcentury Democrats a coalition of Sweden (social welfare) and South Africa (vicious apartheid). The party constantly, often vehemently, negotiated with itself. Much has been made of southern intransigence, even cruelty, on race (Katznelson 2013). At the same time, the two sides

negotiated, accommodated, and logrolled—adjusting to the issue and the political alignment of the moment. The southerners, in particular, were committed to Congress as an institution. Yes, they routinely frustrated health reformers. But left and right Democrats were members of the same party with overlapping ideas and shared political interests. Walter George (D-GA), who chaired the Senate Finance Committee, appears to have blocked Franklin D. Roosevelt from dropping health insurance into Social Security in both 1938 and 1943, but he was indispensable to Roosevelt on foreign policy (Blumenthal and Morone 2009: 47, 51). Being part of a majority coalition kept the liberal's agenda—especially issues like national health insurance—in play and offered them occasional opportunities.

Perhaps the greatest change in recent American politics lies in the end of liberal-conservative intraparty coalitions. Conservatives moved into the Republican Party. Liberals became Democrats (Levendusky 2009). Today the most conservative Democrat in Congress stands to the left of the most liberal Republican. As I noted above, political scientists have been calling for just this kind of party sort in order to enhance the voter's choice; they did not count on the disruptive consequence of all-out partisan contests. American institutions were not organized to process the conflict.

The founders assumed, when they wrote the Constitution, that there would be many factions but no major parties; over time, political institutions evolved to frame parties that were broad coalitions spanning diverse perspectives. The governing frame was never designed to accommodate two clashing parties, united by ideology, struggling for supremacy, and motivated by the desire to win both policies and power.[1]

*Close Competition.* The party sort is exacerbated by an unprecedented run of close elections (Lee 2009). Traditionally, one party dominated. Between 1896 and 1930, the Democrats elected just one president; the Republicans controlled at least one chamber of Congress for thirty-two years, Democrats for just eight. In 1930 the majority flipped. In the next half century (between 1930 and 1980) Democrats controlled at least one chamber for forty-four years; the Republicans managed just four. Today, in contrast, there is no majority party—either one might break through in the next election. Between 1980 and 2016, the Democrats have controlled at least one House of Congress for 25.5 years; the Republicans for 26.5. Likewise,

1. Mark Peterson made this point in response to a talk I gave at the Robert Wood Johnson Foundation's Investigator Awards in Health Policy Research Annual Meeting in 2013. I thank him for the insight.

in those thirty-six years, the Democrats controlled the White House for four terms, the Republicans five.

The close competition erodes incentives to cooperate. Both policy and institutional interests point the same way: resist, disrupt, and aim for the next election. When there is a clear and stable majority party, the minority goes along—out of self-protection, if nothing else. For example, most Republicans opposed Social Security in 1935 (which managed just one Republican vote in the House) and Medicare in 1965 (all but ten House Republicans voted to bury the bill back in committee). But in both cases, once passage was assured, the minority accepted defeat and, by large majorities, voted aye on final passage (misleading casual historians into believing that there was bipartisan support for the measures all along) (Blumenthal and Morone 2009: 192). The sustained battle over the ACA reflects the reality that either party might sweep the next election. Indeed, frustrating the ACA is both a Republican policy goal and path back to power.

*Gingrich Rules.* In Washington lore, Newt Gingrich envisioned a Republican strategy to congressional majority after a half century in the wilderness. He organized for victory by turning policy disagreements into what political scientist Sean Theriault (2013: 5) describes as "all-out partisan war." The conflict changed the political rules of engagement. The old politics—marked by deference, logrolling, and bourbon after hours—all evaporated in the scramble to win. The total political war began in the House around 1978, slowly moved to the Senate (Theriault 2013), and appears to be progressing into the states.

The new conflict is intensified in Congress because legislators do not know one another. They fly into Washington, DC, on Tuesday morning and scurry home on Thursday night. Over one hundred Republicans now reject a Washington, DC, residence and sleep in their offices—proudly touting their outsider status. In a government of strangers there are few opportunities to develop the informal ties and institutional loyalties that, throughout the twentieth century, helped smooth the way to political deals.

An alternate interpretation bluntly blames the Republicans. Jacob S. Hacker and Paul Pierson suggest that the Republicans have moved six times as far to the right as the Democrats to the left. Democrats, more interested in governance, are willing to compromise with Republican leaders (Hacker and Pierson 2005, 2011; Lofgren 2012). This interpretation fits at least one historical theme, which I describe below: Republicans

in power have been effective at formulating health policy. In opposition, they have never been more disruptive, but what will happen the next time they are in control—more ingenious health policy or continued partisan war?

Whether one party or both drove the change, the gulf between party members has grown. Today it would be risible to expect colleagues from across the aisle to act in one's interests—perhaps ever. This makes real-world governance—reliant on compromises and deals—far more difficult.

*The Media.* Thirty years ago, the three networks dominated American news and largely reported the same stories. The "fairness doctrine," dating back to 1949, required media outlets to provide "contrasting" political views. The rule reflected the era's expectations: sober, nonpartisan coverage of news and politics. Then the Reagan administration pushed the Federal Communications Commission to repeal the doctrine just as a dizzy era of technical innovation—cable television, the Internet, and the proliferation of news sources—enabled today's media landscape: a raucous menu of news and politics that reaches across the political spectrum and permits partisans to consume information that reflects and amplifies their own perspective—from the *Daily Caller* (on the right) to the *Daily Show* or the *Daily Kos* (on the left).

## Changing Nation: The Race and Ethnic Sort

Underlying the partisan competition lies a racial sea change. When Lyndon B. Johnson signed the Civil Rights Act he is reputed to have said: "There goes the South." While the quotation is disputed, the electoral consequences are not: the majority of white Americans shifted their vote to the Republican Party. Over the past ten presidential elections, the Democrats have averaged 39 percent of the white vote. Between 1968 and 1992, the result was a series of Republican landslides—in defeat, the Democrats averaged 74 electoral votes (it takes 270 to win), could not hold a single state across the elections, and eked out just one presidency in the shadow of Watergate (Morone and Fauquert 2015).

At first, those numbers pushed both parties to dissociate themselves from African American voters and their issues (Frymer 1999). During the Obama years, political scientists detected a major change: the Democratic Party began to embrace minority voters and their concerns—Katherine Tate (2014) terms the result a "concordance" between black public opinion and Democratic Party policies. The change reflected the growth of the

minority population and its importance in the Democratic Party ranks. By the 2012 presidential election, some 45 percent of the Democratic voters were self-described minorities. On the other side, the Republicans remained a largely white party (estimates from exit polls put the number as high as 89 percent of Republican voters) (Newport 2013).

The result is what we might call a race and ethnic sort. White voters, especially white male voters and overwhelmingly southern white male voters, lean strongly Republican. Nonwhite voters lean very strongly toward Democrats. These leanings raise one of the great contemporary questions in American politics—and, as we shall see, for health policy: Are the large racial differences between the parties baked into the Democratic and Republican organization, message, and appeal? Or might racial issues be negotiable within the parties? If they are negotiable, with what groups and under what conditions?

The questions become especially important in the face of demographic changes that will culminate, over the next thirty years, in a so-called majority-minority nation. A deep partisan divide exacerbated by racial difference would create enormous dislocations in politics generally and health care policy in particular (Morone and Fauquert 2015).

## Partisanship and Health Care

What does the new era of partisanship bode for health care? In this section, I suggest what is different about contemporary health policy. Perhaps the single most important question is whether—and how much—the changes on the national level have reached the states that play an increasingly important role in health policy. The answer may turn on the local dynamics of race and immigration.

### Health Politics Old and New

Partisanship itself is nothing new in health politics. President Harry S. Truman's national health insurance plan detonated an explosion in Congress back in 1946. Senator James Murray (D-MT) opened congressional hearings by asking that members refrain from tagging the proposal "socialistic" or "communistic" out of respect for the president. The minority leader, Senator Robert Taft (R-OH) interrupted: "I think it is very socialistic. . . . It is, to my mind, the most socialistic plan that this Congress has ever had before it." The Red scare, just beginning to stir, gave the charge particular force. Taft followed that up with a gratuitous crack at

the chair—"This committee is being run as a propaganda machine." By the end of the long exchange, Murray was shouting, "You can shut your mouth up and get out" (quoted in Blumenthal and Morone 2009: 77). Taft and his supporters obliged him and boycotted the hearings. The first great national health insurance debate was off to a decidedly partisan start.

Almost twenty years later, Ronald Reagan caught the eye of national conservatives with his flamboyant attack on Medicare: "Behind it [Medicare] will come other federal programs that will invade every area of freedom as we have known it in this country. Until one day . . . we will awake to find that we have socialism. . . . You and I are going to spend our sunset years telling our children and our children's children what it was like in America when men were free" (quoted in Morone 1998: 262). Former vice presidential candidate Sarah Palin joined a venerable rhetorical tradition when she charged the ACA with organizing "death panels" for vulnerable Americans. Nothing in the Obama-era debates broke new ground for partisan ferocity or nastiness.

However, there are three features of contemporary health debates that, at least on the surface, appear to be unprecedented. First, no matter how fierce the rhetoric of past debates, legislative victory brought closure. Even after the harsh twenty-year debate over Medicare, implementation went smoothly. Administrators used the program to desegregate southern hospitals—addressing civil rights in an era when the issue was still explosive. Contrast that to today. There is no precedent—in health or social policy—for a conflict that has gone on for years after the president signed major legislation.

Second, health care politics always included the classic political arts of compromise and bargaining. For example, each time Democrats produced a popular bill, Republicans countered with their own (more market-friendly) proposal. Republicans designed their own legislation every time Medicare came back on the agenda—from the time the Truman administration first proposed the idea in 1952 through the early 1960s when Congress first voted on the idea (Blumenthal and Morone 2009: chaps. 3–4). They countered Senator Ted Kennedy's (D-MA) expansive national health insurance with Richard Nixon's mixed public-private public plan in the 1970s (Feder, Holahan, and Marmor 1980: 2–20). And moderate Republicans, led by minority leader Robert Dole (R-KA), famously proposed an insurance mandate to counter the Clinton administration's plan in the 1990s (Quadagno 2011). Indeed, when the Senate Republicans decided to try to kill the Clinton proposal, many fretted about appearing too partisan—Senator Bob Packwood (R-OR) warned his colleagues, behind

closed doors, to avoid leaving their fingerprints on the corpse (Starr 2011: 103–4). Just three years later, a Republican Congress collaborated with the Clinton administration to pass the State Children's Health Insurance Program (SCHIP), which ended up ensuring health coverage for over 7 million children within a decade. In short, Republicans in opposition balanced political attacks with policy negotiation, public battle with private compromise.

The old pattern began to end in the 1990s when one congressional faction (led by Speaker Gingrich) opposed any compromise with the Clinton administration. Moderates remained queasy about outright opposition (no fingerprints on the corpse). By the Obama administration, the no-compromise faction had no serious rivals left. To be sure, Senator Charles Grassley (R-IA) negotiated over the ACA's details for months on the Senate Finance Committee, but at summer recess, facing Tea Party activists, he stunned his Democratic colleagues by parroting the death panel trope: "You . . . should not have a government run plan deciding when to pull the plug on grandma" (Montopoli 2009). There was no one left to negotiate with the administration, to propose alternatives, to cloak the opposition, or to capitulate and back the reform after passage was assured.

On the contrary, some Republicans flatly announced that their mission was to defeat President Obama. Senator Jim DeMint (R-SC) (2011: 75) put it bluntly: "If we are able to stop Obama on this, it will be his Waterloo. It will break him." Some older Republican senators, like Christopher S. "Kit" Bond (R-MO), who was about to retire, demurred. The debate should focus on policy, not politics or personality. The unabashed partisans, boosted by the rise of the Tea Party, swamped the old-timers. This debate, this era, would be all about beating Obama, winning elections, and burying Democratic health care proposals (Theriault 2013: 3–5).

Third, the Republicans in power were always a very different health care party from the Republicans in opposition. They proved creative and effective at expanding health care coverage—arguably more effective than Democratic administrations. President Dwight D. Eisenhower proposed a reinsurance scheme to facilitate private coverage of high-risk patients and cemented the tax expenditure for employer-sponsored health plans (uncharacteristically waiving away budget concerns raised by Democrats). President Nixon reimagined national health insurance—all subsequent Democratic administrations offered variations of the Nixon plan. President Reagan put aside his long, loud opposition to Medicare and pushed through an expansion to cover catastrophic health episodes despite the objection of almost every cabinet member. (It was repealed a year later after Reagan had

left office.) George W. Bush won another expansion of Medicare to cover prescription drugs. In short, the imperatives of governing led Republicans to change behavior. From Eisenhower to Bush, Republican administrations tried to grasp the health care issue away from Democrats.

The scorched earth approach to the ACA has been an opposition party strategy. What will happen during the next Republican administration? Will it continue the Republican legacy of designing market-friendly health care benefits? Or will the new partisanship—anti-Washington, anti–social welfare policy, even antigovernance—generate a sustained sea change in Republican strategy?

We cannot, as of this writing, know the answer on the federal level. But we can get some sense of Republican strategy by turning to the state governments. From the start, the ACA included extensive state participation and implementation. The Supreme Court handed the states an even more consequential role when it made the expansion of Medicaid (to cover all citizens up to 138 percent of the federal poverty level) voluntary (*National Federation of Independent Business v. Sebelius*). The debate over expansion played out in states across the political spectrum—Democratic, divided, and Republican.

## State Medicaid Expansion: Partisan Lessons from the States

By 2015 thirty-one states had expanded their Medicaid programs. As expected, Democratic states generally expanded quickly. The results in mixed states varied. Two Republican governors facing Democratic legislatures, in Nevada and New Mexico, quickly supported expansion; in Maine, however, a Republican governor vetoed Medicaid expansion and beat a legislative effort to override. More surprisingly, seven states that were entirely in Republican hands passed the reform (or, in Utah's case, continues negotiating). In Arizona, Republican governor Jan Brewer had become a conservative favorite by sponsoring a tough immigration law; after hearing from hospital officials, she demanded Medicaid expansion. To make it stick, Brewer threatened to veto every bill the legislature sent her unless it acquiesced. She made good on her threat until nine Republicans in the House and five in the Senate crossed party lines to vote for passage. In Ohio, Republican governor John Kasich moved to expand Medicaid without the approval of the Republican legislature. And in North Dakota, Republican governor Jack Dalrymple—a strong opponent of the ACA—turned around and pushed Medicaid expansion through a Republican legislature.

Why did some all-red states move? Dalrymple's change is instructive. For starters, the federal government's 90 percent federal match for Medicaid funds proved alluring. More important, he faced a concrete problem that affected identifiable interests in his state: hospitals in North Dakota, like hospitals everywhere, face the problem of patients who cannot pay. Nationally, very roughly 6 percent of hospital costs are uncompensated. Hospitals that serve a large number (or a disproportionate share) of uninsured patients have a strong incentive to lobby for expansion (Coughlin et al. 2014). And note the striking difference from the federal politics: rather than the "hospital industry" or the American Hospital Association lobbying for Medicaid expansion, state legislators often see familiar faces from Altru Hospital in Grand Forks or St. Peter's Hospital in Helena. State politics feature familiar, influential individuals discussing problems in local institutions (they invariably deny lobbying altogether). Opponents must persuade the states to deny visible institutions—and to find alternative funding for their hospital's uncompensated care burden.

That neatly fits the American federalism textbook. State-level politics has a reputation for practical decision making. Legislative choices have a more immediate impact on visible institutions and identifiable populations. The early days of the Medicaid expansion debate seemed to quietly reflect the old truism about state politics being less partisan and more oriented to solving problems. As Dalrymple put it when he submitted the North Dakota expansion: "We try to leave the politics out in the hallway when we make these decisions" (quoted in Young 2013).

However, the partisan alternative also emerged. Twenty states have stoutly refused expansion, often with language that nationalizes the state policy process. In Texas, for example, the Republican supermajority unanimously rejected expansion; in Nebraska, Republican governor Dave Heineman opposed the program, and the Republican majority filibustered it to defeat. Many conservative states have strong antigovernment sentiments. Count on local groups, funded by national conservatives, to fight against entitlement spending. Opponents have framed the debate as a check on welfare. "How would you feel as parents and citizens," asked Carl Graham (2013) of the Montana Policy Institute, "if our children got a taste of living on welfare [through Medicaid expansion]?"

Moreover, national debates increasingly echo on the state level. The traditional wisdom held that all politics was local; now local politics often reflect the national party contests. Interestingly, the losers in Washington regularly recoup in the states. An anti-Democratic tide ran through the states during the Bill Clinton years when Democratic control of state

legislatures fell from twenty-nine states (in 1990) to just sixteen (by 2000); the Democrats won back most of those legislatures by the end of the Bush years (twenty-seven state legislatures in Democratic hands) only to lose them all over again in the Obama years (nineteen state legislatures by 2014). By the end of the Obama administration, the Republicans will have controlled more state governments than they had in almost ninety years: they hold the governor's office in twenty-nine states and both chambers in twenty-seven (including Nebraska, which only has one). During the Obama years, strong attacks on the ACA have accompanied the powerful tide of state governments back into the red column.

In short, two trends mark health policy in the states: a long legacy of compromise and problem solving faces off against a growing tendency to take Washington's partisan wars to the state level (Shor 2014). Perhaps the most important question for future health policy is which trend proves more durable. One hint may lie in America's greatest political cleavages—race and immigration.

## Race

Despite great aspirations about a postracial America, the Obama era has made race increasingly visible as an issue—and appears to have injected it into health care politics (Kinder and Dale-Riddle 2012). In 2012 Michael Tesler drew on two decades of panel data and dozens of media polls and discovered that "racial attitudes had a significantly larger impact on health care opinion in fall 2009" than they had in surveys and panel data "collected before Obama became the face of the policy." The racial divide in public opinion was 20 percent higher during the Obama effort than it had been during Clinton's reform (Tesler 2012: 690). Likewise, Michael Henderson and D. Sunshine Hillygus (2011: 960) suggest that health care policy preferences became increasingly "tinged" with racial attitudes with the arrival of President Obama.

The racialization of health policy appears to reflect the dynamics of Medicaid expansion. Of the ten states with the largest percentage of African Americans, eight rejected Medicaid expansion. The nays included states with entirely blue governments (Mississippi, Louisiana, and Alabama were all Democratic in 2010) and states with mixed control (like Virginia). On the other side, the Republican-controlled states that did extend Medicaid generally had small African American populations—the average was 5.7 percent of the state census.

Interestingly, the same dynamic is not operating for Latino politics. Of the ten states with the largest Latino populations, eight expanded Medicaid. Five of those had Republican governors, and one (Arizona) was entirely in Republican hands. Why the difference when race and immigration are both so hotly contested? The answer does not appear to lie in the state population numbers, which are very roughly the same size—for example, Mississippi is 37 percent black (and ranks first in that demographic), while California is 37.6 percent Latino (and ranks second).

Perhaps the difference lies in local institutions. The southern states long ago developed institutional mechanisms—notably the all-white party—to limit African American political influence; white voters have an easily legible political mechanism designed for both ideological and racial control. The rise of Hispanic immigrants is a more recent phenomenon, and opposition to social policy benefits has not been institutionalized.

In any case, the study of both African American and Latino populations requires a great deal more attention before we understand how racial attitudes have changed the politics of health care. And only time will tell if the changes are a permanent part of the policy system. However, the deeply racialized dynamic running through the party sort, described above, echoes recent surveys and panel data: racial divisions, refracted by partisan politics, appear to be playing a growing role in American health care politics and policy—at both the national and state level. Perhaps these trends simply reflect the Obama years. Perhaps, over time, pragmatic state politics will win out over both partisanship and race. Or we may find that long-standing American divisions—us and them, the good and the dangerous, the makers and the takers—will reassert themselves, that partisanship will complicate health politics and policy, and that racial divisions will shape politics and policy, both on the federal level and in the states.

## Conclusion: Party Differences and Health Care Policy

Parties and political conflict are essential for democracy. The venerable wish (dating back to Washington) that politicians might put aside their differences and just solve problems has always been chimerical. However, over the past generation, partisanship has taken on a new intensity, unprecedented in modern American politics and driven forward by parties that are united over policy and in a tight competition for control. This competition has set a new frame for health care policy—and embroiled the ACA in unusually disruptive politics. Can we expect more of the same in

the years ahead? Or are the Obama years an exception? Consider the evidence for each alternative.

There are two reasons to expect a less partisan health policy in the future. For starters, the national Republican Party has played a very different role in power than in opposition. The next Republican administration may very well find itself split between two imperatives. On the one hand, it no longer has a liberal wing—the Republican base is largely united in opposing government intervention in health markets; on the other hand, the imperatives of governance will likely push it (as it has pushed every previous Republican administration) toward an active health policy. The debate between true believers and pragmatists—already raging in the Republican Congress—will likely embroil the next Republican administration and have much to do with the framing of health care politics in the years ahead.

The other reason is that the states are increasingly important in shaping health policy. Many of the partisan dynamics that have changed national policy—impersonality, the lack of familiarity with other legislators, the hyperpartisan media—are less likely to be true in state capitals. In most states, the actors and the institutions are well known to one another. It may be easier to develop the sense that others "will act in one's interests" in a smaller, more stable political environment.

An alternative future would see the hyper partisanship of the Obama years grow into the new normal. The parties are fundamentally different than they were a generation ago, and past Republican administrations may not be a reliable guide to the behavior of future ones. Moreover, the states may prove to be no bulwark against partisan intensity. As Madison foresaw, a small political environment can be dangerous for minority interests (Madison 1788). We saw above that American political parties have undergone a racial and ethnic sort: Democrats are, increasingly, the party of minorities. The Republican voters have become predominantly white. This stark division is unprecedented. Through the nineteenth and early twentieth centuries, Republicans championed African Americans and sought to restrict immigrants; the Democrats embraced immigrants and, through states' rights, supported segregation. Now the two parties break on race *and* ethnic lines—precisely the lines that mark classic American stereotyping. Racial and ethnic strangers have repeatedly been imagined into dangerous people with un-American values, morals, or religions: Irish Catholics, Russian Jews, Asians, Mexicans, Muslims, and upwardly mobile African Americans have all been constructed into the immoral other (Morone 1997, 2003). The bigotry has major consequences for health and welfare programs since support (and opposition) for programs often flows from

images of the beneficiary—are they welfare queens or people who work hard and play by the rules? The new partisanship—sorted by race and ethnicity—yields very different answers and images in the different parties. We face a danger that the current party division will push race and ethnic fears into election contests, policy debates, and health care programs. If so, the debate over the ACA will indeed become the new normal—on both the national level and in the states.

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