Report on Health Reform Implementation

Medicaid Expansion: A Tale of Two Governors

Robin Flagg
University of California, Berkeley

Editor's Note: JHPPL has started an ACA Scholar-Practitioner Network (ASPN). The ASPN assembles people of different backgrounds (practitioners, stakeholders, and researchers) involved in state-level health reform implementation across the United States. The newly developed ASPN website documents ACA implementation research projects to assist policy makers, researchers, and journalists in identifying and integrating scholarly work on state-level implementation of the ACA. If you would like your work included on the ASPN website, please contact web coordinator Phillip Singer at pmsinger@umich.edu. You can visit the site at http://ssascholars.uchicago.edu/jhppl/.

JHPPL seeks to bring this important and timely work to the fore in Report on Health Reform Implementation, a recurring special section. The journal will publish essays in this section based on findings that emerge from network participants. Thanks to funding from the Robert Wood Johnson Foundation, all essays in the section are published open access.

—Colleen M. Grogan

Abstract This is a study of why two seemingly similar governors made divergent decisions on expanding Medicaid under the Patient Protection and Affordable Care Act (ACA). Performing a case study of Governors John Kasich (OH) and Scott Walker (WI), I explore the roles played by electoral pressures, political party, governor's ideology, the state's policy heritage, stakeholder advocacy, and the economy in each governor's decision about whether to expand Medicaid. Electoral pressure was the most significant factor for both governors. I demonstrate that even Walker succumbed to state electoral pressures and expanded Medicaid, albeit in a manner unique to Wisconsin. He

Journal of Health Politics, Policy and Law, Vol. 41, No. 5, October 2016
DOI 10.1215/03616878-3632243

did this despite his emphatic national rhetoric rejecting Obamacare and expansion. Additionally, existing state political institutions drove each governor to decide in a manner unique to his state: previous Medicaid decisions in Wisconsin and direct democracy in Ohio provided additional pressures and divergent starting points. The remaining factors served less as a driving force behind the decision and more as a frame to justify the decision ex post facto. Case studies allow for a more complex view of how political pressures fit together; differences can be explained and expanded, and an enhanced understanding of political processes can be gleaned.

Keywords governor decision making, Medicaid expansion, ACA, state politics, federalism, path dependence, electoral pressures

Introduction

Governors are subject to cross-pressures that make their jobs challenging. Budgetary pressures may drive policy contrary to personal ideology, and existing state infrastructures may restrict decisive moves. Add to the equation political pressures—in particular the pressure to align with partisan positions—and a governor is faced with a myriad of opposing and interrelated factors when taking a position. Policy decisions are extremely complicated and nuanced.

This is a study of two seemingly similar governors who made divergent decisions on expanding Medicaid under the Patient Protection and Affordable Care Act (ACA). Using case studies of Governors John Kasich (OH) and Scott Walker (WI), I explore the role political party, personal ideology, state policy heritage, stakeholder advocacy, and the state economy played in each governor's decision regarding Medicaid expansion under the ACA.

With the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, existing funding arrangements between the federal and state governments may be fundamentally changed. Because of this new application of the coercion doctrine to federal–state partnership programs, states now have increased latitude when deciding how and when to participate in joint programs (e.g., Medicaid, State Children's Health Insurance Program [SCHIP], Temporary Assistance for Needy Families [TANF], and educational and housing programs) (Rosenbaum and Westmoreland 2012). Given this new flexibility, an increased understanding of influences upon governor decision making is critical. Additionally, because states collect a growing proportion of all government revenue and play an ever-increasing role in social welfare provisions, studying state action

and how and why certain decisions are made is crucial to understanding the future viability of social welfare programs (Campbell 2013).

Background

President Barack Obama signed the ACA into law on March 23, 2010. A main component of the ACA was expansion of Medicaid to include everyone with incomes below 133 percent Federal Poverty Level (FPL).[1] The expansion was projected to add 16 million people to Medicaid (KFF 2010). Attorneys General from twenty-seven states filed suit against the federal government challenging the constitutionality of the law (Jacobs and Skocpol 2012). In June 2012, in their *National Federation of Independent Businesses (NFIB) v. Sebelius* decision, the US Supreme Court upheld the constitutionality of the requirement that all Americans have affordable health insurance coverage. At the same time, the Court found mandatory Medicaid eligibility expansion unconstitutional.[2] However, five justices ruled in favor of *allowing* the Medicaid expansion to continue with enhanced federal funding, thereby rendering the expansion voluntary and leaving the decision of whether or not to expand up to each state (*NFIB v. Sebelius* 2012; Rosenbaum and Westmoreland 2012). Consequently, by July 2013 each governor had to decide whether or not to support expansion.[3]

Conservative Republicans John Kasich and Scott Walker were elected as part of the 2010 Tea Party sweep of governorships (Gabriel 2014); both sought reelection in 2014 in states that voted for President Obama in the 2012 presidential election; and both are GOP candidates in the 2016 presidential election. Each state would gain millions in federal dollars were it to expand Medicaid. In addition, both states are midwestern manufacturing states that faced large budget deficits during the recession. Importantly, both

1. Prior to this change, Medicaid eligibility was tied to both poverty level and categorical qualification. For example, a pregnant woman would qualify for Medicaid with an income level below 133 percent FPL, a parent would qualify with an income below 75 percent, and a childless adult would not qualify (KFF.org 2010).

2. The justices invoked the coercion doctrine, deciding that states had no real choice but to expand given that nonexpansion would result in termination of their existing Medicaid program. Additionally, a 100 percent federal match was deemed too coercive. States argued that this provision was more like a "gun to the head" and thus inconsistent with federalism and state rights (Rosenbaum and Westmoreland 2012).

3. This decision was predominantly made along party lines. As of June 2013, 80 percent of Democratic governors supported expansion, and 60 percent of the Republican governors opposed it. However, even more predictive was how the state electorate voted in the 2012 presidential election. Eighty-one percent of governors in states that voted for Obama decided to expand, whereas 71 percent of governors in states that voted for Romney decided against expansion.

governors came to national attention in 2012 in their attempts to dismantle collective bargaining rights of unions. Walker survived a very high-profile recall election that came as a result of his attack on the state's unions. Kasich, however, saw his enacted bill against collective bargaining overturned in a state initiative process. Both battles drew national attention and support for both sides. Finally, and specific to the ACA, both governors espoused anti-Obamacare positions, joined the lawsuit against the ACA, and decided against a state-run health exchange. However, despite these similarities, Governor Kasich opted to expand Medicaid, whereas Governor Walker opposed it.

Via a case study analysis of these two seemingly similar governors, I flesh out the countervailing pressures that drove the governors to divergent outcomes.

Influencing Factors

The literature suggests a number of factors that potentially influence a governor's decision making. Politicians make policy decisions based on their electoral concerns, their ideological beliefs, and their pragmatic judgments about what is best for their constituents, their state, and the country (Rom M. 2013). Research aligns their position with their party's platform: Theda Skocpol argues that governors are under extreme pressure to follow their party line and thus, partisanship is the driving factor in decision making (Jacobs and Skocpol 2012; Skocpol 2013). Because of the role parties play in elections, candidates are indebted to their party and must not stray too far or risk losing support (Aldrich 1995; Bawn et al. 2001; Cohen et al. 2009; Karol 2009; Abramowitz 2010). Consistently, Jacobs and Callaghan found that Medicaid expansion in states with Democrats in power moved faster and farther than implementation in states with Republicans in power (Jacobs and Callaghan 2013).

Others argue that party is not relevent. Specifically, Erikson, Wright, and McIver found that Republican and Democratic officials "ultimately enact the same policies when given the responsibility of governing; reacting to social needs and economic constraints at the expense of campaign pledges or ephemeral political considerations" (Erikson, Wright, and McIver 1989). They found that nonpartisan pressures (e.g., the economy) drive ideologically diverse officials to make similar decisions. Specific to the question at hand, they might argue that the largesse of increased federal funding tied to Medicaid expansion would ultimately drive the governor's decision.

Medicaid history is instructive. Within five years of its inception in 1965, nearly all states had implemented a Medicaid program even with a substantial state investment (Kaiser Commission 2012). In 1982, Arizona—the last holdout—adopted Medicaid when officials succumbed to advocates' criticism of their failure to capitalize on millions of available federal dollars. Advocates argued that Arizonans were paying federal taxes to support Medicaid programs in other states without receiving federal help for their own indigent health care programs (Brecher 1984).

The ACA provides for 100 percent federal financing (Federal Medical Assistance Percentage [FMAP]) for two years, declining over the years to 90 percent FMAP in 2020 and thereafter. Between 2013 and 2022, states could realize an additional $800 billion in federal dollars as a result of Medicaid expansion (offset by an estimated $76 billion in state costs) (Holahan J. et al. 2012). Additionally, the influx of funds could have a profound impact on the broader state economy, quantifiable in terms of employment, income, state revenue, and overall economic output (Kaiser Commission 2013). Many argue that the magnitude of federal funding would ultimately convince the decision makers that this is an offer that can't be refused (Skocpol 2013). One set of researchers went as far as to say that the ACA was "buying states' acquiescence" (Jacobs and Skocpol 2013). At the conclusion of an April 2013 speech, Theda Skocpol was asked, "In 10 years' time, how many states will have opted to expand Medicaid?" Skocpol unequivocally answered, "All of them . . . They can't afford not to; there's too much money at stake" (Skocpol 2013).

States are different and so are the policies they enact. A state's ideology, culture, and history all play into state policy decisions (Erikson 1993; Baumgartner, Gray, and Lowery 2009; Kousser and Phillips 2012; Gray 2013). Regional differences in manufacturing and labor markets drive divergent benefits and coverage for welfare, unemployment insurance, and Medicaid (Springer 2012; Gray 2013; Jacobs and Skocpol 2013). State demographics also drive difference. For example, Florida has a high percentage of elderly living within its borders, thus focusing much political attention on long-term care (including Medicaid[4]) policies (Rom M. 2013). And, because Latinos have been concentrated primarily in the Southwest, immigration policies and other issues of importance to the Latino vote are highly salient in these states (Gray, Hanson, and Kousser 2013). Once policy decisions are made and programs

4. Although the elderly comprise approximately 25 percent of Medicaid beneficiaries nationwide, they are responsible for over two thirds of the dollars spent (KFF.org 2013).

enacted, future decisions are constrained. Paul Pierson argues that "policy creates both politics and context within which lawmakers determine feasible options" (Pierson 1995). For example, coverage expansion under (SCHIP) is defined not only by the upper income eligibility for SCHIP, but also by the "floor" where Medicaid coverage stops and SCHIP coverage begins (Rosenbach et al. 2003). Specific to this study, "decision-making on Medicaid expansion may be influenced by state policies toward low-income people and the uninsured—especially policies regarding eligibility and benefits—that were established prior to the ACA" (Jacobs and Callaghan 2013). Thus, a state's past policy choices not only reflect its past ideology but also indicate what policies are likely to be enacted in the future.

Others argue that it is how the policy influences future elections that matters. David Mayhew found that congressmen are professional politicians who make politics a career, with the main goal being reelection (Mayhew 1974). In a 2001 review of his earlier work, Mayhew reasserted that "politicians get rewarded for taking positions rather than achieving effects. The member-centered electoral drive seems to be alive and well on Capitol Hill" (Mayhew 2001). Justin Phillips agreed, finding that "once in office, officials' desire to win re-election gives them the incentive to legislate in a way that is consistent with what their constituents want" (Phillips 2013). Politicians diligently calculate their actions, their words, and the policies with which they are associated as being either supportive of or detrimental to their ultimate goal: reelection.

Different than Mayhew, Fenno argued that policy makers seek to make "good" policy; they act because they think an action is worthwhile even if it has no political payoff (Fenno 1978). This argument suggests that if a candidate's personal belief about what is good policy is at odds with the policy that is most likely to win an election, candidates must decide whether to hold true to their policy preferences or to moderate their platform to align with voters (Baumgartner, Gray, and Lowery 2009). Timothy Barnett agreed, finding that elected officials do make policy decisions that are inconsistent with their constituents' beliefs: In 1995 and 1996 Republicans shut down the government despite the fact that large majorities of voters opposed that action. He argues that members cared more about doing what they perceived to be the right thing than getting reelected (Barnett 1999).

Another factor to consider is the role of interest groups. According to David Truman, groups are natural and inevitable, forming and mobilizing when interests are threatened (Truman 1951). Furthermore, highly salient

issues spur increased participation (Oshifski and Cunningham 2008). Because of the economic effect of social policies, businesses are increasingly concerned with social policy-making (Brace 1993). Skocpol argues that stakeholder groups (in particular hospital groups) will work to ensure expansion in all states because expansion would virtually eliminate uncompensated care (Skocpol 2013). In a two-party system, peak associations form to represent the business voice (Vogel 1996; Thelen 2001; Martin and Swank 2004). These peak associations (i.e., trade associations) are established for the purpose of supporting their members in occupational issues, lobbying government, and generally promoting their members' interests (Edsall 1984; Brace 1993; Martin and Swank 2004). The two associations of most relevance to this study are the American Medical Association (AMA) and the American Hospital Association (AHA).[5]

The Story of Two Governors, the Same but Different

Researchers argue that single-state case studies provide valuable means of exploring interactions within a political system; and that selecting states based on the behavior under study is appropriate (Stonecash 1996; see also Collier and Seawright 2010; Rogowski 2010; and Kousser 2014). Thus I study why two seemingly similar governors—John Kasich and Scott Walker—took divergent positions on the question of Medicaid expansion under the ACA.

In addition to performing content analysis of speeches, news articles, and relevant reports, I interviewed key informants at the state and national levels. These were semi-structured interviews with open-ended questions aimed at better understanding how a governor decided upon a position.[6] To ensure that each interviewee was able to offer his own explanation, my first question was "Why do you believe the governor decided to expand/not expand Medicaid?" Only after the first question did I ask about the role of each factor in the governor's decision making. Using a snowball effect to select interview participants, I performed hour-long in-person interviews with stakeholders, administration officials, legislators (or their staff), journalists, and university officials in both states. After each meeting, I asked for referrals to additional people. In this manner, I worked until I reached

5. Representing nearly 5,000 hospitals, health care systems, and networks across the country, the "AHA works with its members, state and regional affiliates, and other organizations to shape and influence federal and state legislation and regulation to improve the ability of its members to deliver quality health care" (AHA 2013).

6. This research was granted exemption status by the UC Berkeley Office of Protection of Human Subjects (OPHS) on June 13, 2013 (CPHS Protocol Number: 2013-05-5344).

saturation, achieving agreement from all participants that I had met with the full array of major respondents. I spent five days in each state capital, interviewing 13+[7] people in Madison (March 3–7, 2014) and in Columbus (March 10–14). In addition, phone interviews were performed about Governor Walker (n = 3) and Governor Kasich (n = 2). Finally, I spoke with two respondents at the national level to obtain more global input.

Governor Scott Walker (R-WI)

In 2010, Walker won the election for governor of Wisconsin in a Tea Party groundswell. Since then, consistent with his conservative ideology and the Republican Party, he has steadfastly refused to implement any part of the ACA, first arguing that the Supreme Court would find it unconstitutional, and after the Court decision in June 2012, banking on Governor Romney winning the presidency and subsequently repealing the law (Mukherjee n.d.). In an op-ed in the *Washington Post* on July 12, 2012, Governor Walker wrote, "Although the Supreme Court has ruled on the constitutionality of the Act . . . it is bad policy. . . . Obamacare will devastate Wisconsin" (Walker 2012). Thus it was no surprise that in his February 20, 2013 State Budget Address Walker announced his opposition to expansion.

Walker did face pressures to expand Medicaid. The progressive nature of the state, which led to its already low number of uninsured, ensured ongoing support for helping those in need[8] (KFF 2011). As for electoral pressures, although Walker survived a recall election in 2012, his breaking of unions' right to organize in Wisconsin sharply divided the state's electorate. And, in November 2012, only months after the recall election, Wisconsin voters helped elect President Obama to his second term. Finally, like other states, Wisconsin was hit hard by the Great Recession of 2008–09. In September 2013, Moody's Analytics named Wisconsin as one of three states with the weakest recovery in the country (Prah 2013). This suggests that the economic benefit of federal funds for the expanded Medicaid population should push Walker toward expansion. And in fact, just prior to Governor Walker going public with his decision, an article in the *Milwaukee Journal Sentinel* stated:

7. The + indicates that more than one person was present during an interview. A list of persons interviewed and questions asked is available from the author.

8. Wisconsin had 11 percent uninsured in 2011–12, giving it the seventh lowest number of uninsured in the country. The national uninsured rate was 15 percent (http://kff.org/other/state-indicator/total-population/).

> For [Walker], neither option is attractive. As an opponent of the ACA Walker may be loath to give even tacit support to the law. But expanding the Medicaid program could bring hundreds of millions of federal dollars into the state each year and billions of dollars over the next decade. (Boulton 2013)

Party. When asked about the role of party in motivating Walker's decision, interviewees consistently responded that Walker was the party leader and had party support (Moran 2014). Wisconsin's State Assembly, with a large majority of Republican seats (60R: 39D) (Wisconsin State Government 2014) was described as "very conservative" (Stein 2014) and "aligned with the Governor" (Abrams 2014). And, although there "was some push from less conservative Republican Senators to take the federal money, they took the governor's lead and voted along party lines" (Rude 2014). One respondent acknowledged that had Walker advocated for full expansion, it too "might have passed had he pushed for it" (Rude 2014). Jon Peacock of the Wisconsin Council for Children and Families agreed: "I think he has enough clout within his party that even expansion could have gotten through both houses" (Peacock 2014). Many respondents felt that prior to Act 10,[9] a partisan divide was not evident in Wisconsin. "People used to vote across tickets regularly" and "it wasn't about the party it was about the issue" (Abrams 2014; Oliver 2014) were examples of comments I heard. Nonetheless, Walker's strength as a party leader was bolstered by his recall survival.

Ideology. Walker regularly espoused a conservative ideology. Using market forces to improve the economy while at the same time reducing the size and range of government were ubiquitous themes in his speeches and policy initiatives. The main theme in his 2013 State Budget Address was the economy: "Improving the economy is my number one priority." Additionally, Walker promoted entitlement reform: "We must pursue reforms that help people transition from government dependence to true independence" (Walker 2013). Consistently, Walker's Deputy Secretary of Health Services Kevin Moore said, "One of the governor's favorite talking

9. Act 10 ended collective bargaining for all but a few unions (e.g., police and fire). Walker was able to push his legislation through the Republican-controlled legislature but only after a lot of drama. Democratic Representatives left the state in the middle of the night in order to delay a vote, hundreds of thousands of protestors camped out in the state capitol for weeks, and protesters on both sides came to Wisconsin from across the country. Ultimately the Act was signed into law; however, opponents quickly collected enough signatures to force a recall election of Governor Walker. Walker survived the recall attempt in a June 5, 2011 election (Stein and Marley 2013; see also Assembly Bill 11, "Act 10," 2011).

points is that he views success by the number of people who get off of entitlements" (Moore 2014; see also Peters and Radnofsky 2013). A third theme of his speech was his lack of trust in the federal government: "I said no . . . because if I expanded Medicaid I'd be dependent on the same federal government that can't get a basic website up . . . to come through with payments for Medicaid in the future" (Martin 2013). Respondents echoed these conservative themes when describing Walker: "He's a true conservative who believes in limited government," "[he] is opposed to government hand-outs," "[he] is an ardent states' rights advocate," "he deeply distrusts the federal government" and "[he] aligns with pro-market advocates" (Abrams 2014; Brenton 2014; Moran 2014; Peacock 2014; Reimer 2014; Stein 2014). Other comments included the following: "[his] expressed goal . . . was to move Medicaid back to serving only the very vulnerable; he wanted to return Medicaid to a true safety net. He believed all people above the poverty level should have 'skin in the game'" (Brenton 2014; Friedsam 2014); and "Walker only wanted to give Medicaid to those below 100% FPL. To him, Medicaid is too generous" (Whalberg 2014).

State Policy History. History matters. Under previous governors Thompson (R) and Doyle (D), the state received federal waivers which allowed Wisconsin to combine SCHIP, Medicaid, and other federal health care funds[10] into "BadgerCare," making it one of the most expansive Medicaid programs in the county. Under BadgerCare, children and pregnant women were covered up to 200 percent FPL with the ability to buy into a benchmark plan if they fell below 300 percent FPL. Parents and child caregivers were covered up to 200 percent FPL. And most generously, childless adults were provided with basic benefits under the program if they had incomes below 200 percent FPL. This latter category was restricted in number and ultimately closed to new enrollment due to budgetary constraints (Davis 2014; Legislative Fiscal Bureau 2013).

Thus, when deciding to expand Medicaid under the ACA, Governor Walker was, in reality, considering both an expansion (removing the cap on all childless adults currently barred from enrollment in BadgerCare) as well as a reduction (moving those above 133 percent FPL from BadgerCare into the Exchange). In numerical terms, these two changes would result in close to a zero net impact in the total number of Medicaid beneficiaries.

10. Funds used to cover the expansion populations under the Wisconsin BadgerCare 1115 waiver included the federal disproportionate share hospital (DSH) used to help hospitals pay for the uninsured.

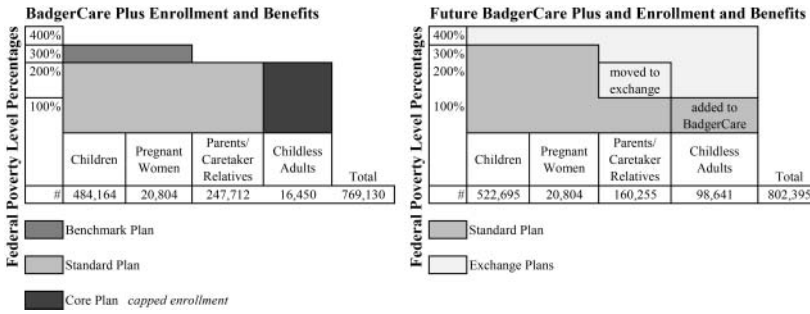

Figure 1 Wisconsin Badgercare Pre- and Post-"Expansion"

Source: Wisconsin Regional Enrollment Outreach Strategy presentation (PowerPoint) at Town Hall Meetings, 9/13. www.dhs.wisconsin.gov/health-care/ren/legislative-briefing.pdf.

Walker chose to move all people with incomes above 100 percent FPL[11] into the Exchange, thereby reducing his Medicaid rolls. However, he also made the decision to enroll all persons under 100 percent FPL into the existing BadgerCare program (see figure 1). Because this decision was made outside the ACA provisions for Medicaid expansion, this expansion population would be treated as waiver-based eligibles and thus the state would be eligible for only its regular FMAP of 60 percent, not the 100 percent FMAP under the ACA.

Walker had a very different starting point and thus a different set of options. Specifically, in his words:

> Our actions allow us to reduce the number of uninsured in our state by 224,580. We also reduce the net number of people who are on . . . Medicaid. Some 87,000 people living above poverty will transition into the private or Exchange markets, where they can get a premium for as low as $19 per month. At the same time, we are able to add 82,000 people currently living in poverty [onto Medicaid]. Going forward, everyone living in poverty will be covered under Medicaid. (Walker 2013)

11. Because the US Senate and House of Representatives passed different policy bills that were never reconciled, there are some inconsistencies in the legislation. Of relevance to Wisconsin is that while expansion of Medicaid is required to 133 percent FPL—both have a 5 percent income disregard allowing those with 105 percent and 138 percent respectively to enroll in both programs. This means Walker can move enrollees between 133 percent and 100 percent FPL out of Medicaid and into the Exchange, allowing them to have access to federal subsidies, whereas had he expanded Medicaid, federal subsidies would not have been available to anyone below the 133 percent threshold and thus the number of people he would have transitioned into the exchange would have been far less.

Respondents agreed that the greatest factor influencing the governor's decision not to expand Medicaid was the starting point of the state's existing program. "Because of the legacy of earlier Governors, Walker would, at a minimum, have to decide what to do with those persons who were enrolled in Medicaid but qualified for federal subsidies under the ACA" (Stein 2014). Others agreed: "Our starting point was so different, on paper we already had the authority to cover all those targeted for Medicaid expansion" (Olson and Davidson 2014); "Governor Walker looked at the cards he was dealt by former Governors Doyle and Thompson, [cards] that allowed him to make the decision he did" (Friedsam 2014); "He was getting the benefit of a policy legacy which allowed him to make a minimal change, vocally reject ACA expansion, and still get credit for increasing the number of insured in Wisconsin. All this because of previous expansive policies" (Oliver 2014). Walker's Deputy Secretary for Health summarized this point well: "[Governor Walker] had the luxury of doing something other than expanding or not; his decision was based on our existing policy" (Moore 2014). And finally, the Director of Medicaid said, "[you] need to recognize that what was done in Wisconsin could not have been done in any other state; rather from whence you came, forward you can go . . . It's all about the starting point for the state" (Davis 2014).

Economics. Many argue that the amount of federal money on the table will ultimately make it hard for any governor to resist expanding Medicaid. Walker, however, argued that the enhanced federal funding "could not be trusted," "the money wasn't really on the table," and that ultimately an expanded program "would leave the state with a huge financial burden" (Boulton 2014; Olson and Davidson 2014; Friedsam 2014; Peacock 2014; Reimer 2014). The nonpartisan Legislative Fiscal Bureau found that the governor's proposal would cost the state $119 million more than expansion under the ACA. Respondents agreed that the governor was making a decision that did not make economic sense. "Many of us thought the economic argument would trump ideology but we were wrong" (Peacock 2014). Hospitals in particular were concerned that there would be more uncompensated care when those above 100 percent FPL were moved into the Exchange. To address their concern, Walker included an additional $100 million in the budget to cover the indigent (Brenton 2014).[12] The

12. Stakeholders discussed the irony of the governor on one hand advocating for his plan, which would result in all persons receiving coverage, while at the same time providing hospitals with funds to cover the uninsured, thereby acknowledging the insufficiency of his plan (Davis 2014; Brenton 2014; Olson and Davidson 2014).

Administration responded as follows to questions regarding the economics of the decision: "True, the governor did not draw down as much federal money as he could have; but there was no guarantee that the FMAP would be there. A 60/40 match is safer to rely upon. In the end, we were willing to take less federal money because the governor didn't trust the federal government" (Davis 2014). Others argued that the expansion without enhanced funding didn't garner much attention. A Democratic legislative staffer stated that the "money left on the table was a non-issue . . . the Republicans lined up behind the Governor in support of his proposal" (Moran 2014). Another staffer stated that "leaving the $119M state dollars on the table was all part of the budget process so [we] didn't need to address [it] separately . . . we could 'hide' the decision. Economically it would have been smarter to take the money but the governor argued that we couldn't trust the federal dollars"[13] (Rude 2014).

The economic factor in Walker's calculus could be viewed as a nuisance. He addressed leaving federal money on the table by continuously repeating his mantra "We can't trust the federal government," by putting extra funds into the budget to keep the hospitals quiet, and by cloaking the entire debate within the overall budget discussion.

Electoral Pressures. In July 2015, Governor Walker joined the ranks of Republican 2016 presidential candidates (Healy 2015). But, before he decided to run for president he had to win reelection in Wisconsin in November 2014. The question I set out to answer was whether Walker considered his reelection as governor and, potentially, his election as president when deciding to expand Medicaid under the ACA. Every respondent believed that Walker considered *both* elections. And because of the divergent audiences for each election, the framing of his position varied accordingly. A December 2013 *Wall Street Journal* description of Walker's position stated, "His approach allows him to combat criticism either for accepting the federal money or blocking a Medicaid expansion" (Peters and Radnofsky 2013). Many agreed that Walker was in fact playing to two audiences: "Nationally he was playing to the Tea Party while locally, playing to a more liberal constituency, he was very vocal about expanding Medicaid" (Reimer 2014).

13. Representative Nygren's (R) staffer acknowledged that he did not think "not trusting the federal government for the money" was a strong argument; but he asserted that it didn't matter because the decision was part of the larger budget discussion and thus no accommodation had to be made for the "lost" money (Rude 2014).

Moran states that "[Walker] made a political calculation that this wouldn't really hurt his re-election" (Moran 2014). However, an October 2013 poll by Marquette University Law School found that 56 percent opposed Walker's decision not to take federal Medicaid expansion money. In the same poll, Walker was leading Mary Burke, the Democratic nominee, by just two percentage points (Peters and Radnofsky 2013). Not surprisingly, Burke's first policy position after winning the Democratic primary was to support Medicaid expansion (Brenton 2014; Stein 2014). Abrams commented that although Walker survived his recall election, in the next statewide election President Obama won by eight points and liberal Tammy Baldwin overwhelmingly beat Tommy Thompson for the Senate. "Walker had to be worried about the statewide race. He had to win or his presidential election is a pipe dream" (Abrams 2014). Peacock praised Walker's political acumen: "It is clever political triangulation; he has to cover enough people to get re-elected in a state that has the history of covering many, while at the same time saying 'no' to Obamacare so he can continue to endear himself to the Tea Party. He can promote a different message in each venue" (Peacock 2014). While leaving money on the table was dangerous within Wisconsin, taking the money would have been dangerous in the presidential primary (Friedsam 2014; Stein 2014; Brenton 2014). In Wisconsin Walker's mantra was about "cutting the number of uninsured in half" and "ensuring health care options to all those living in poverty" (Walker 2013). Nationally, however, Walker complained about the reach of Obamacare, refusing to implement any part of it (Walker 2012; Friedsam 2014). Respondents discussed the irony of Walker opposing Obamacare while at the same time, because his plan depended on the success of HealthCare.gov, actively promoting it to residents (Friedsam 2014; Reimer 2014; Henderson and Shepherd 2014; Stein 2014). Secretary Moore agreed: "Governor Walker has the obligation to make the ACA work in Wisconsin . . . this is not about politics, this is his way of showing the country what he did in Wisconsin" (Moore 2014). When pushed, Moore admitted that Walker's plan allowed him to "have his cake and eat it too" (Moore 2014).

Interest Groups. Given Governor Walker's proposal to "cut the number of uninsured by half . . . and provide BadgerCare to everyone living in poverty" (Walker 2013), stakeholders were neutralized. Instead of arguing on behalf of expansion, they were instead arguing specific policy details: which program for which people at what FPL. Furthermore, many stakeholders agreed that because "Republicans controlled the legislature,

lobbying for full expansion under the ACA was 'dead on arrival' " (Abrams 2014). Others described the Wisconsin Medical Association (WMA) and the Wisconsin Hospital Association (WHA) as pro-Walker groups who did not want to anger the governor but agreed to lobby "behind the scenes" for full expansion, as they agreed that many would be confused by private insurance under the Exchange (Boulton 2014; Reimer 2014; Stein 2014; Whalberg 2014). In response to the question of why hospitals weren't "leading the pack in favor of expansion" as they were in other states, I was told:

> "Hospitals already lost their DSH money. . . . They did advocate for full expansion but were conflicted because Medicaid reimbursement rates were lower than rates would be under the Exchange. . . . Ultimately, they cut a deal with the Governor for extra funds. They signed our coalition letter, but they never really fought. They took care of themselves." (Peacock 2014)

Hospital members were concerned that many between 100 and 133 percent FPL (moved into the Exchange under Walker's plan, but remaining in Medicaid under full expansion) could not afford the cost-sharing required under the Exchange, thus putting hospitals at risk for increased uncompensated care. While they agreed that drawing down more federal funds and covering more people in Medicaid was probably better, they supported the governor's ultimate goal of covering everyone and thus didn't fight publicly (Brenton 2014). When asked about the additional state money the hospitals had received, Brenton acknowledged that they had been able to get additional funds by working quietly behind the scenes (Brenton 2014).

Other stakeholders aggressively pushed for full expansion. "Service Employees International Union, Citizen Action, faith-based groups, disabilities groups all advocated for expansion. They never conceded that the governor's plan . . . covered all; instead they focused on the federal money left on the table" (Peacock 2014). Jason Stein agreed that there were stakeholders advocating for expansion but felt that "the pressure to expand was not overwhelming" (Stein 2014).

Stakeholders stood to gain regardless of approach. In order for Walker's plan to work, the federal Exchange had to be a success. Thus the governor's administration allocated resources to ensure the success of Healthcare.gov despite its overall opposition to the ACA. Anticipating an increase in the number of insured and the possibility for everyone to obtain coverage, many stakeholders expected to gain personally from the governor's plan. Managed care plans, clinics, hospitals, and doctors all anticipated growth

both in Medicaid and in the private insurance market. Representatives from the Wisconsin Primary Care Association said, "The stakeholder coalition worked hard to not make this political . . . rather we wanted to work together to reduce the number of uninsured" (Olson and Davidson 2014). Representatives from Molina Health Plan, a managed care plan with a mission of serving the underserved, agreed to join the coalition in support of full expansion of Medicaid. However, Molina remained "neutral" in its lobbying efforts, as it would serve patients both via BadgerCare and the Exchange, and in fact, would receive a higher reimbursement rate through the Exchange (Henderson and Shepherd 2014).

There was a general belief that Walker had support from Tea Party groups outside the state (Whalberg 2014; Rude 2014; Stein 2014). Numerous articles in national papers discuss Walker's relationship with Americans for Prosperity (AFP) and its founders Charles and David Koch (Lipton 2011; Sargent 2012; Singer 2012; Whitesides 2012). In fact, the Koch Industries' Political Action Committee contributed the maximum amount allowed by law to Scott Walker's 2010 gubernatorial campaign (Wisconsin Government Accountability Board 2014). The AFP also supported Walker with independent expenditures (Lipton 2011). The press continued to track Walker's fundraising efforts with outside conservative groups (Gabriel 2014). While many respondents felt Walker was concerned with his relationship with the Koch brothers and other outside groups, they did not believe that he was overly influenced by these groups on this decision. "Had they pressured him I doubt he would have expanded BadgerCare to cover those below 100% FPL" (Brenton 2014).

Like the economic factor, interest group pressure did not appear to be a major factor in Governor Walker's decision making. Rather, because of policy decisions of previous adminstrations, stakeholders were complacent and less assertive than might have been expected.

Personal. Many described Walker as ambitious (Abrams 2014; Brenton 2014; Friedsam 2014; Peacock 2014; Reimer 2014). Others said he was smart, and "that one should not let the fact that he didn't finish college confuse the issue" (Shepherd 2014; Reimer 2014; Stein 2014). People who worked closely with him described him as a policy wonk who was deeply involved in the details of policy (Moore 2014). Others said he was religious, an Eagle Scout, and the son of a preacher (Henderson and Shepherd 2014). No single description surfaced that would cast new light on his decision making relative to other factors considered.

Divergent Frames for Different Constituents

Given that Wisconsin is a progressive state with traditionally liberal policies and that Wisconsin voters helped elect President Obama in 2012, Walker's decision not to expand Medicaid appears inconsistent with his voters' desires. Walker did, however, respond to electoral pressures, but in a manner that allowed him to respond to two different constituencies simultaneously: those in his campaign for reelection as governor and those who would support his potential run for president. He was able to use past policy decisions to his advantage: he enrolled new people into BadgerCare while at the same time moving those above the poverty line out of BadgerCare and into the Exchange. He was able to do this without expanding Medicaid under the ACA yet neutralizing the stakeholder pressure for expansion. He was able to frame his Medicaid policy in a manner that appeased both progressive state constituents in his reelection campaign and the conservative anti-government Tea Party voters in a potential 2016 presidential primary election.

Both Walker's ideology and party affiliation drove him to oppose expansion. The economic consideration would have led him to expand, but because of past changes to Wisconsin's Medicaid program, the amount of money on the table was significantly less than in other states.[14] While stakeholders urged Walker to expand, they did not lobby aggressively, realizing that they would "win" either way, as even with a "no" decision on expansion the number of uninsured would be reduced and additional funds to cover uncompensated care would be provided.

Governor John Kasich (R-OH)

One week prior to being elected governor in 2010, Kasich posted the following to his campaign website: "Today I signed The Ohio Project's initiative petition to amend Ohio's Constitution and preserve Ohioans' freedom to make their own decisions about health care. Obamacare must be blocked" (Kasich 2010). And yet, in his 2013 State Budget Address, Governor Kasich announced, "This budget also takes the significant step of helping low-income and working Ohioans have access to health care through Medicaid . . ." (Kasich 2013).

14. Wisconsin was forecast to draw down $2,402 per capita in FMAP were it to have expanded Medicaid. The average per capita increase among all states is $2,925, ranging from $1,312 in Minnesota to $5,249 in Mississippi.

Which factors moved Governor Kasich to favor expansion in spite of his expressed opposition?

Party. Although elected with strong GOP and Tea Party support, Kasich bucked his party with his decision to expand Medicaid. Immediately after he announced his support for expansion, the Tea Party backed a candidate to challenge him in the primary for his reelection bid. However, within a week, the candidate decided against running, claiming that "while many within the GOP are unhappy with some of the decisions Governor Kasich has made, he has the support of many within the party and the funding to carry it through to the general election" (Gomez 2014; Lachman 2014). The conviction that Kasich ultimately had the support of the GOP was addressed in most interviews: "Party members realized that Kasich's armor was so strong that they 'would waste money challenging him' " (Maglione 2014); "Speaker Batchelder and the Republican Party didn't support expansion but they did support Kasich" (Rohling McGee 2014; Allison and Reiss 2014; Corlett 2014); "While there are factions within the Ohio GOP, Kasich is viewed as their leader and ultimately garners their support" (Hayes and Sahr 2014). Reporter Laura Bischoff agreed:

> The Republicans love him. He is their governor. There are two small factions that are unhappy with him: the fiscal conservatives over his decision to expand Medicaid and the social conservatives because he hasn't passed the heartbeat bill.[15] However the large majority is loyal to him. The current party chairman, Matt Burgess is a "Kasich Man." The party has his back. (Bischoff 2014)

Respondents described a Republican caucus within the House of Representatives that was split with "20 of us supporting expansion, 20 strongly opposing, and 20 likely supporting but praying they wouldn't have to vote on it" (Sears[16] 2014; Rohling McGee 2014). Ultimately, party leaders' main concern was to avoid a vote on the issue as a vote would tear the party apart and ensure Tea Party challengers for those representatives who supported taking the federal money (Archey 2014; McCarthy 2014; Moody 2014; Sears 2014). Kasich's strength as leader allowed him to go against the GOP platform and yet retain support.

15. The heartbeat bill would ban all abortions after the fetal heartbeat is detected.

16. Representative Sears was regularly credited with being the lead House Republican pushing for support of Kasich's budget (Maglione 2014; Rohling McGee 2014). She noted in our interview that her Tea Party opponent in her May 6, 2015, primary received "over $50,000 from Tea Party supporters outside of Ohio" (Sears 2014).

Ideology. Kasich has a long voting record[17] upon which his ideological leanings can be evaluated. OnTheIssues ranks Kasich as a "conservative" because of policy decisions that indicate "he believes that standards of morality and safety should be enforced by government, that individuals should take personal responsibility for financial matters, and that free-market competition is better for people than central planning by the government" (OnTheIssues.com 2014). When campaigning for governor in 2010, Kasich's rhetoric replicated Republican themes of small government, market-based responses to social issues, and anti-Obama and anti-Obamacare sentiment (Kasich 2010). Consistently, Kasich governed with conservative goals. Everyone interviewed affirmed his conservative reputation: "He's a small government, low tax guy" (Hayes and Sahr 2014; also Allison and Reiss 2014; Archey 2014; McCarthy 2014; Saelens and Robertson 2014). Additionally, Kasich espouses conservative social policies such as opposition to gay marriage, a ban on abortions, and support for teaching creationism in schools (OntheIssues.com; also Hayes and Sahr 2014).

Despite his conservative ideology, respondents believed that "Kasich expanded Medicaid because he thought it was the right thing to do" (Archey 2014; Johnson 2014; Levine 2014; Maglione 2014; Rohling McGee 2014). One respondent argued, "He believes that government's role is to help those who can't help themselves; not the poor, but the vulnerable" (Johnson 2014). Director Moody responded to my questions about the inconsistency with "It was a justice question; like it or not, [Kasich] knew the ACA was here to stay and it wasn't fair if the poor didn't get coverage while those with incomes over 100 percent would receive a federal subsidy to purchase health care. He viewed this as inequitable and felt he had to right the injustice" (Moody 2014).

Economic. Researchers at the Ohio State University College of Medicine (OSU) calculated a net fiscal gain to Ohio were it to expand Medicaid. Even with the loss of DSH funding and the likely increase of enrollment by nonexpansion beneficiaries due to the woodwork effect,[18] revenue would increase under expansion. Between 2014 and 2022, the net income

17. Kasich was a state senator from 1979 to 1982 and US Representative from 1983 to 2001 (www.govtrack.us 2014).

18. The "woodwork effect" refers to the people previously eligible for Medicaid but not enrolled. When they come "out of the woodwork" and sign up—a likely event given the outreach to all persons under the ACA—states will receive their traditional FMAP for this population, rather than the enhanced 100 percent FMAP for the ACA-expansion population (Academy Health Blog 2013).

resulting from the expansion was projected to be $1.8 billion (HPIO, OSU et al. 2013). The lure of billions of dollars was powerful: "We have an unprecedented opportunity to bring $1.8 billion of Ohio's tax dollars back to Ohio to solve our problems. Our money coming home to fix our problems" (Kasich 2013). A *Columbus Dispatch* editorial supported his position: "The benefits [of covering an estimated 275,000 low-income people] accrue to everyone: People who can get preventive care won't end up in emergency rooms with conditions that have grown unnecessarily serious and expensive. This lowers medical spending overall and eases hospitals' burden for uncompensated care, which should help lower premiums for those who have insurance" (*Columbus Dispatch* February 21, 2013).

Every person interviewed agreed that money drove the issue, that there was just too much money on the table to say no (Archey 2014; Hayes and Sahr 2014; Johnson 2014; Levine 2014; Maglione 2014; Rohling McGee 2014; Seiber 2014). Not only would the federal government cover 100 percent of the costs for the expansion population for the first two years, but because of the 6 percent Medicaid managed care sales tax, Ohio would have net revenue beyond the cost of care (Moody 2014). Director McCarthy said, "Just looking at the numbers, with no politics, there was no reason not to do this" (McCarthy 2014). Representative Sears (R) confirmed that, by framing the decision as part of the larger budget, it made fiscal sense to expand (Sears 2014).

The governor made two additional arguments about the economics of expansion. First, Ohioans' federal income tax dollars would go to other states if Ohio didn't expand. Specifically, he argued that "if we don't do what we should do on Medicaid, they'll be spending our money in California" (Kasich 2013). And second, investing in those in need would help save money in the long run. A respondent described the governor as a shrewd businessman who was aware of not just the new money coming in but the additional savings that would accrue to prisons, hospitals, child welfare, and homeless support. "The governor is a believer that if we provide needed care, especially mental health care, to those in need, people will start caring for themselves and thus reduce the overall cost to the state" (Johnson 2014).

Policy History. Past policy decisions and established political institutions rendered Kasich's decision unique. Two political institutions in Ohio are of relevance to this study: the ballot initiative process and the presence of the Controlling Board (Board). The 1910 Ohio Constitutional Convention amended the Ohio constitution to allow for direct democracy by enabling

citizens to place an issue directly before voters on a statewide ballot (Ohio Attorney General's Office n.d.). In the year prior to the Medicaid decision, Kasich's bill restricting workers' rights to collectively bargain was overturned in a landslide. It was the pressure of a potential ballot initiative requiring the expansion of Medicaid that "pushed Speaker Batcheldor to work with Kasich on the expansion. Batcheldor was worried that an initiative would make the expansion a constitutional amendment—he is a constitutional attorney and felt strongly that this issue didn't belong in the constitution. With an initiative he knew this was likely to happen" (Saelens and Robertson 2014; Allison and Reiss 2014; Archey 2014; Bischoff 2014; Hayes and Sahr 2014).

The second institution of relevance is the Controlling Board, established in 1917 to "oversee the allocation of certain capital and operating expenditures by state agencies" (Ohio Office of Budget and Management 2014). Because the Board was charged with dispersing funds, Kasich believed that it could allocate the additional funding for Medicaid expansion without requiring a legislative vote. This entity became vital to the ability of the Republicans to expand the program without splintering the party as a vote would have done. "The potential for using the Board was always in the back of our minds when we discussed the pros and cons of expansion" (McCarthy 2014).

When elected, Kasich elevated Medicaid to the department level and created the Office of Health Transformation (McCarthy 2014). The two new directors immediately set out to streamline and create efficiencies in the Medicaid program. According to the Director of Health Transformation,

> When I started, [it] was a given that we would expand Medicaid.[19] But the program was swamped and overwhelmed. Program costs were increasing at 10% annually. [We] reduced the program costs to a 3% annual growth rate by the time the question of expansion came up. I wouldn't have recommended expansion if we were still at a 10% growth. (Moody 2014)

Stakeholders supported Director Moody's assessment: "Kasich believes that Medicaid is flawed when run as in Illinois, but when enrollees are in managed care, that's OK, and the expansion was going to be via private managed care plans" (Archey 2014). "[Director] Moody had a whole framework in place to transform health care delivery. He had already

19. The ACA was the law of the land and the Supreme Court decision rendering Medicaid expansion voluntary had not yet been decided.

worked to simplify Medicaid. He was expanding Medicaid managed care. His plan included payment reform. The Governor hired Greg Moody; he believed in it" (Levine 2014). "[Moody]'s focus on reforming and streamlining the administration process was in place well before the issue of Medicaid expansion came up" (Saelens and Robertson 2014). "Greg [Moody] has a sense of policy and politics and was already engaged in transforming health care; we were improving the program" (Rohling McGee 2014).

Another prior decision facilitated the governor's position on expansion. Beginning in 2010, a 6 percent sales tax has been levied upon Medicaid managed care plans. The sales tax is included in the plans' capitation rates and thus is reimbursed by the state via Medicaid payments that are matched at 60 percent FMAP by the federal government. For the newly eligible Medicaid beneficiaries the entire 6 percent tax will be paid by the federal government. This money will pass through the health plans, providing increased revenue to the state (HPIO, OSU et al. 2013). Thus, the decision to expand Medicaid is better than cost neutral to Ohio for the first two years when FMAP is 100 percent. It is a revenue enhancer.

Electoral Pressures. Respondents believed that Kasich was not worried about a primary challenger in his reelection campaign (Hayes and Sahr 2014; Johnson 2014; Levine 2014; Maglione 2014). The director of the liberal Universal Health Care Action Network Ohio gave a reason for Kasich's confidence regarding his reelection: "Cleveland's African American voter turnout is always horrible in off-presidential-election years. This helps Kasich, and the Republican candidates in general. He would have a harder time winning were the election held in a presidential election year" (Levine 2014). However, despite assertions that reelection concerns were minimal, many of those interviewed discussed how Kasich had to moderate his position to retain power in Ohio: "[Ohio] is a purple state that voted for Obama. Those on the right had nowhere to go. [Kasich] had taken a hit when he pushed 'Right to Work';[20] . . . he had to stake out the middle for a general election" (Maglione 2014). This idea was echoed by many: "Kasich needed to moderate towards the center . . . he got killed on SB 5" (Bischoff 2014); "[He] moved to the middle purposefully . . . [he] went too far on the unions and needed to self-correct" (Archey 2014); and "Medicaid expansion has taken a lot of intensity out of the union issue;

20. SB 5 —"The Right to Work" —restricted freedom of association by prohibiting workers and employers from agreeing to contracts that include fair share fees, forcing dues-paying union members to subsidize services to non-union employees (www.actohio.org/right-to-work/).

he is now considered moderate" (Allison and Reiss 2014). It appears as if reelection concerns directly drove this policy decision.

Despite his staff's contentions that he was not planning to run for president, Kasich announced his candidacy (Allen 2015). More than one interviewee discussed the relevance of the Medicaid issue to a potential presidential run: "His decision will hurt him in Ohio but it may help him when he runs for President" (Maglione 2014) and "This will hurt him in that Republican primary but would help him in a general election" (Bischoff 2014).

Interest Groups. When asked about the role of stakeholders in Kasich's decision-making process, Moody said "I knew where stakeholders fell and I wouldn't have recommended 'yes' if I didn't think [we] had their support" (Moody 2014). Everyone agreed that the coalition formed to advocate for Medicaid expansion was crucial to the governor's decision (Archey 2014; Bischoff 2014; Hayes and Sahr 2014; Johnson 2014; Levine 2014; Maglione 2014; McCarthy 2014; Moody 2014; Rohling McGee 2014; Saelens and Robertson 2014). The coalition included over seventy-five stakeholder groups representing very diverse interests. The Ohio Hospitals Association (OHA), Care Source Health Plan, and the SEIU were the lead financial backers of the coalition but numerous other organizations also provided support (Allison and Reiss 2014). Various grassroots advocacy and chamber groups participated (Allison and Reiss 2014; Levine 2014). The OHA was the stakeholder group with the most to gain or lose in the effort and thus played a lead role with the coalition (Allison and Reiss 2014; Archey 2014; Maglione 2014). In 2010, Ohio's annual DSH allotment from the federal government was $363 million, funds meant to cover costs associated with uncompensated care in 190 hospitals (Department of Health and Human Services OIG 2006). With the loss of these funds under the ACA, OHA strongly supported expansion in order to reduce the uncompensated drain on hospitals (Archey 2014). Ohio physicians came into the coalition later: "The Ohio State Medical Association (OSMA) didn't support the ACA; many of our members were concerned about supporting Medicaid expansion. Our members were split down the middle. We had to reconcile our opposition to the ACA with support for expansion. We ultimately got there and joined in with Coalition efforts" (Maglione 2014). Medicaid managed care plans, having a lot to gain financially from expansion, actively supported the coalition (Saelens and Johnson 2014). Grassroots organizations participated in the coalition and welcomed the opportunity to work alongside groups they were often in disagreement

with (Levine 2014). In addition, behavioral health advocacy groups were core members (Allison and Reiss 2014; Johnson 2014). Respondents agreed that the coalition's purpose "was to keep the pressure on the political process" (Maglione 2014; Archey 2014; Levine 2014). One source of pressure was the coalition support for a ballot initiative that would require Medicaid expansion under the Ohio constitution (Allison and Reiss 2014; Archey 2014; Johnson 2014). Director McCarthy agreed that it was the fear that there might be a ballot initiative requiring Medicaid expansion that ultimately pushed Speaker Batcheldor to facilitate the passage of the expansion via the Board (McCarthy 2014).

Personal. There were clearly personal components to the governor's decision making, in particular his Christian faith and his extended family. When asked why he chose to expand Medicaid despite his belief in smaller government, he answered, "[It's the] mission [my] Christian faith has called [upon me] to shoulder: 'helping the poor, the beleaguered and the downtrodden, and trying to heal them and lift them up'" (King 2013). Multiple news articles mocked his Christian-based justification of his decision with headlines such as "John Kasich: God Wants Ohio to Expand Medicaid" (Hart 2013) and "Medicaid and the Apostle Kasich—The Ohio Governor's lawless, faith-based Obamacaid expansion" (*Wall Street Journal* 2013). Nonetheless, Kasich regularly invoked religious-based justifications of his position with quotes such as "When you die and go to heaven, St. Peter is probably not going to ask you much about what you did about keeping government small. Instead he is going to ask you what you did for the poor" (King 2013; Candisky and Hallet 2013).

Another personal reason may have played into his decision. Linking the expansion of Medicaid to getting more people into treatment for mental health and substance abuse is another theme of Governor Kasich. This may derive in part from his having a brother with mental illness (Gabriel 2013). Others too listed Kasich's brother as a factor influencing his decision (Bischoff 2014; Johnson 2014; Rohling McGee 2014).

Electoral Pressures Must Be Considered in Context

It is easy to say that Kasich gave in to electoral pressures when deciding to expand Medicaid; he chose a policy that would appease his more liberal voters and thus ensure his reelection as governor. This case study endorses that finding. However, when viewed holistically, other factors also played a role. Given the existence of the initiative process, one could argue that

Kasich was ultimately stripped of his true decision-making power because had he not opted for expansion, he would have been forced to accept it as a fait accompli. What truly drove the process is difficult to tease out: Was it the cross-electoral pressures or the threat of the initiative process? Likely both played a role.

Kasich's Christian belief that he must "provide for those in need" was a pro-expansion factor. However, it is possible that rather than driving his decision, Kasich invoked his religion as a means of justifying a decision that was forced upon him as a result of electoral pressures. In other words, it may be that the electoral cross-pressures that Kasich faced in a purple state were so great that all other factors were merely justification for the decision, ex post facto. Again, how these factors interacted and the causal direction of each is difficult to ascertain but should be considered before drawing conclusions.

Both stakeholder support and economics supported expansion. The stakeholder coalition and the increased funding for Ohio clearly played into Kasich's decision making. Conversely, the governor's party affiliation and his personal belief in small government and lower taxes likely provided negative pressure to his calculus.

The Puzzle of *Walker v. Kasich*

The goal of this case study was to resolve why Governors Walker and Kasich decided differently despite similar electoral pressures. I entered this study believing that electoral pressure was the most significant factor driving the governors' decisions to expand Medicaid, a pressure that Walker was somehow able to evade. At my first interview, I was told, "The answer [to your question] is easy: 'Both Governors Walker and Kasich took on the unions . . . one prevailed and the other got spanked' " (Abrams 2014). After researching both cases, I agree. And furthermore, I believe this conclusion is in fact proof that governors' electoral challenges are their paramount concern.

Although he decided against what the majority of Wisconsinites supported, Walker was able to appease voters by framing his decision not as a "no" but rather as a "solution for Wisconsin." By framing his decision as the "safe choice," Walker was able to deflate the opposition. And because of his ability to control the conversation, Walker was able to position himself in a manner that not only supported his reelection campaign but will also benefit him when he runs for president. Specifically, he can claim that he did not enact Obamacare while still pacifying his more liberal state

constituents by the fact that he expanded Medicaid to the uninsured. Governor Kasich, on the other hand, likely opted to expand Medicaid because he needed to moderate in order to survive politically. This was a result of his loss over the anti-collective bargaining issue.

I believe that both Walker and Kasich were considering running for president when deciding upon expansion. Another puzzle: if both have their eye on the GOP presidential nomination, why would they come to differing decisions on this issue? Thad Kousser suggested that they may be staking out different paths to the presidency: that Walker's decision would benefit him in the primary as it speaks to conservatives, whereas Kasich's decision is more likely to resonate with the voters in a general election (Kousser 2014).

Additionally, each state had institutions in place that either facilitated the governor in deciding consistent with his party platform and personal ideology (Walker) or drove the governor to decide in a manner that was inconsistent with both his party and ideology (Kasich). Because of previous generous expansions, Governor Walker was able to move all uninsured poor people into BadgerCare without growing the overall program (by moving an equal number from BadgerCare to private coverage). In this manner, he was able to promise health coverage to all Wisconsinites without expanding Medicaid under the ACA. In Ohio, Governor Kasich faced a different set of established institutions, namely an initiative process that limited his ability to lead the state away from the preferred outcome of its median voters.

The two governors applied different weights to the three remaining factors. Kasich argued that if Ohio did not use the available federal funding, another state would. Walker, on the other hand, framed the federal dollars as mythical. The resulting question becomes whether the different dollar values—$58 billion ($5,024 per capita) over 10 years in Ohio and $14 billion ($2,409 per capita) over 10 years in Wisconsin—result in divergent outcomes, or whether the governors' arguments regarding the economics of the decision were merely frames used to justify their previously determined positions. The answers cannot be determined by this research.

The role of stakeholders varied in the two states. Again there is the question of causal direction. Were the stakeholders in Wisconsin less committed to Medicaid expansion than those in Ohio, or did they merely accept that Walker's position would prevail and thus act strategically to avoid a losing battle? In my opinion, the stakeholders in Wisconsin concluded that their ultimate goal of increased coverage would be realized without expansion of Medicaid under the ACA, and thus that they need not expend any political

capital fighting the governor. Both governors were keenly aware of where the stakeholders were vis-à-vis the issue. Governor Walker provided the WHA with additional funds in order to placate them, whereas Governor Kasich enlisted stakeholders' support to promote his decision.

The causal direction of the personal factor in the governors' decision making cannot be determined by this study. Kasich argued that his religious beliefs drove him to decide in favor of expansion. However, it is plausible that Kasich instead succumbed to electoral forces and subsequently invoked his religious beliefs as a means of curtailing the cross-pressures at play. In this scenario, Kasich used his religion as a frame to justify a decision.

These two cases demonstrate the complexity of the strategy of cross-pressured governors. Walker displayed his political acumen by creating a hybrid solution out of a seemingly binary decision. Both governors framed their decisions in a manner that was meant to pacify those with competing perspectives. Walker first undermined the economic forces pushing for a "yes" decision by suggesting that the federal funds were not reliable and then pacified the proponents of expansion by promising Wisconsinites health insurance. Kasich's use of religion served as a frame that could provide a rationale to those on the right who would otherwise advocate for smaller government and fewer government handouts for the underserved.

Limitations

There are limitations to this study. First, the causal mechanisms cannot be teased out, as an interplay among these seven factors exists within an ever-changing hierarchy of influences: the environment is dynamic. As Alan Weil, executive director of the National Academy of State Health Policy, answered when asked which factor(s) were paramount: "You've got the right factors but you cannot weigh one against another. They all play a role. And each plays a different role at a different time" (Weil 2014). Second, a post-decision interview cannot capture the exact tensions and weight of considerations imposed upon the governor at the time of decision. Additionally, no political decision, no matter how salient, can be analyzed in a vacuum. Governors face a myriad of issues simultaneously, creating a complex labyrinth for decision making, one that cannot easily be disentangled.

Conclusion

There are three main findings from this study: First, Mayhew's conclusion that members of Congress legislate in a manner that promotes their

reelection appears to apply in this case of governor decision making. Second, history matters. Earlier policy decisions and previously established political institutions create unique options in each milieu. Finally, when studying variation across states, a case study offers enhanced and nuanced findings.

While electoral pressure appears to be the most significant factor, other factors were clearly involved. Data suggest that many of these factors may have played a role not in position taking but rather as justification for the decision. By using a case study, I demonstrated that Governor Walker did succumb to state electoral pressures and expand Medicaid, albeit in a manner unique to Wisconsin. He did this despite his emphatic national rhetoric in which he asserts his outright rejection of Obamacare and Medicaid expansion. Furthermore, the case study highlighted that other factors may have served less as a driving force behind the decision and more as a powerful frame to justify the decision ex post facto. Additionally, the case study provided rich information that rendered general conclusions overly simplistic. First, in Ohio, for example, the entire process of moving the decision out of the budgetary process and to the Controlling Board was an attempt to avoid a polarizing vote. Second, the interviews provided an understanding as to why stakeholders acted as they did. On the surface it appeared as if the stakeholders in Ohio were powerful and successful whereas those in Wisconsin were weak and unable to influence their governor. Instead, the data showed that Wisconsin stakeholders were faced with a different set of choices than those in Ohio, which led to a different outcome. The discrepancy in how the two states' stakeholders behaved is further explained by the data, which revealed that the WHA received additional monies to address their loss of funds resulting from Walker's choice, undermining their opposition. Perhaps the most important example of why an in-depth case study is recommended is the finding that cross-state comparisons requiring binary variables can oversimplify the question and miss the nuanced answer. Specifically, this study calls Governor Walker's "no" decision on expansion into question. Case studies allow for a more complex view of how political pressures fit together; reasons for differences can be explained and expanded, leading to an enhanced understanding of political processes.

Whether one can extrapolate from this highly visible redistributive welfare policy to other policies is questionable. Even if one argued that this policy is less about welfare and more about federalism and economic policies, the magnitude of political pressures and the exposure this issue brought forth likely separates it from the vast majority of issues a governor

must address. Although the extreme anti-Obamacare partisan rhetoric likely renders this question unique, I believe that the ultimate finding of this study, that small-d democracy plays a large role in governor decision making, would be upheld on other policies.

Other states would provide interesting data for this study and thus warrant an extended case study. For example, other red governors in purple states: Bob McDonnell [R-VA] and Tom Corbett [R-PA] have faced extended political pressure on the issue of expansion, with Governor McDonnell ultimately being replaced by a vocally pro-expansion Democratic governor, one who continues to face difficulties in pursuing his pro-expansion policy. Additionally, a study of Governors Brewer (R-AZ) and Dalrymple (R-ND) might be of interest given their outlier positions of supporting expansion despite being in red states.

Small-d democracy is alive and well. Because governors, like congressmen, are profoundly concerned with how their constituents view them, they ensure that their positions on salient and visible issues are either consistent with those of their voters or can be explained in a manner that neutralizes any divergence from the majority position. In the end, all politics is local, and politicians must maneuver a frame to address their own situations. In order to accurately assess how a governor manages the sometimes opposing pressures of ideology and politics, an in-depth case study is called for.

■ ■ ■

Robin Flagg is a lecturer of Health Policy and Management in the School of Public Health at the University of California, Berkeley. Dr. Flagg has over twenty years of experience in health policy development and advocacy. Her research interests include state policy making and health care politics.

References

Abramowitz, A. 2010. *The Disappearing Center: Engaged Citizens Polarization and American Democracy.* New Haven, CT: Yale University Press.

Abrams, R. 2014. (President, Wisconsin Medical Association.) Interview by the author, March 3.

Academy Health blog. 2013. "The 'Woodwork Problem' and Medicaid Expansion." http://blog.academyhealth.org/the-woodwork-problem-and-the-medicaid-expansion/.

ACTOHIO blog. 2013. "What Is So Called RIGHT TO WORK?" http://www.actohio.org/right-to-work/.

AHA (American Hospital Association). 2013. www.aha.org/ (accessed July 11, 2015).
Aldrich, J. 1995. *Why Parties?* Chicago: University of Chicago Press.
Allen, M. 2015. "John Kasich to Announce 2016 Presidential Bid July 21." In *Politico.com*, June 28, 2015. http://www.politico.com/story/2015/06/john-kasich-2016-presidential-bid-119517.
Allison, J., and N. Reiss. 2014. (Partner and Attorney, Carpenter, Lipps and Leland.) Interview by the author, March 14, 2014.
Archey, J. 2014. (Director, Federal Relations Ohio Hospital Association.) Interview by the author, March 13, 2014.
Assembly Bill 11, Act 10. Legislative Documents State of Wisconsin. http://docs.legis.wisconsin.gov/2011/related/acts/10.pdf (accessed June 28, 2011).
Barnett, T. 1999. *Legislative Learning*. New York and London: Garland.
Baumgartner, F., V. Gray, and D. Lowery. 2009. "Federal Policy Activity and the Mobilization of State Lobbying Organizations." *Political Research Quarterly* 62: 552–67.
Bawn, K., M. Cohen, D. Karol, S. Maskett, H. Noel, and J. Zaller. 2001. "A Theory of Political Parties." Paper presented at 2006 Annual Meetings of the ASPA.
Bischoff, L. 2014. (Staff Writer, *Dayton Daily News*.) Interview by the author, March 14, 2014.
Boulton, G. 2013. "Should Wisconsin Expand its Medicaid Program with Federal Dollars? It's a Question Scott Walker and the Nation's 49 Other Governors Face." *Milwaukee Journal Sentinel*, January 26.
Boulton, G. 2014. (Journalist, *Milwaukee Journal Sentinel*.) Interview by the author, February 29, 2014.
Brace, P. 1993. *State Government and Economic Performance.* Baltimore, MD: Johns Hopkins University Press.
Brecher, C. 1984. "Medicaid Comes to Arizona: A First-Year Report on AHCCS." *Journal of Health Politics, Policy and Law* 9, no. 3: 411–25.
Brenton, S. 2014. (Senior Policy Analyst, Wisconsin Hospital Association.) Interview by the author, March 4, 2014.
Campbell, A. L. 2013. "Dire States: Fiscal Effects and Policy Choices During the Great Recession." Project proposal to the Russell Sage Foundation. Provided by permission of proposal author.
Candisky, C., and J. Hallett. 2014. "Kasich Makes Faith Argument for Medicaid." *Columbus Dispatch*, June 19, p. 2013.
CMS (Centers for Medicare and Medicaid Services). 2014. "Medicaid Eligibility Provisions under the Affordable Care Act." www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html.
Cohen, M., D. Karol, H. Noel, and J. Zaller. 2009. *The Party Decides: Presidential Nominations Before and After Reform.* Chicago: University of Chicago Press.
Collier, D., and J. Seawright. 2010. "The Quest for Standards: King, Keohane, and Verba's Designing Social Inquiry." In *Rethinking Social Inquiry*, edited by H. Brady and D. Collier, 33–64. Plymouth, UK: Rowman and Littlefield.
Columbus Dispatch. 2013. "Kasich Plan Makes Sense: Lawmakers Should Put Aside Partisanship in States Best Interest." Editorial, February 21.

Corlett, J. 2014. (Vice President, Government Relations and Community Affairs at MetroHealth Medical Center.) Interview by the author, February 2014.

Davis, B. 2014. (Director of Medicaid.) "Lessons Learned and Looking Ahead: BadgerCare Plus in the New Year." PowerPoint Presentation to 2014 Mega Conference.

Davis, B. 2014. (Director of Medicaid.) Interview by the author, March 6, 2014.

DHHS (US Department of Health and Human Services). 2006. Office of the Inspector General."Audit of Selected States' Medicaid Disproportional Share Hospital Programs." Report A-06-03-00031.

Edsall, T. 1984. "The Politicization of the Business Community." In *The New Politics of Inequality*, Thomas Edsall, 111. New York: Norton.

Erikson, R. G. 1993. *Statehouse Democracy: Public Opinon and Policy in American States.* New York: Cambridge University Press.

Erikson, R., G. Wright, and J. McIver. 1989. "Partisan Elections, Public Opinion and State Policy." *American Political Science Review* 83: 729–50.

Fenno, R. 1978. *Home Style: House Members in their Districts.* Boston: Little Brown.

Friedsam, D. 2014. (Director, Health Policy Programs.) Interview by the author, March 6, 2014.

Gabriel, T. 2013. "Ohio Governor Defies G.O.P. with Defense of Social Safety Net." *New York Times*, October 28.

Gabriel, T. 2014. "In Governors' Races This Year, Lessons for 2016." *New York Times*, February 2.

Gomez, H. n.d. "Todd Portune Knocks, Ted Stevenot Balks and Dennis Kucinich Mocks: Ohio Politics Roundup." www.cleveland.com (accessed January 6, 2014).

Gray, V. 2013. "The Socioeconomic and Political Context of States." In *Politics in the American States: A Comparative Analysis*, edited by V. Gray, R. Hanson, and T. Kousser, 1–29. Washington, DC: Sage Press.

Gray, V., Hanson R., and Kousser, T. 2013. *Politics in the American States: A Comparitive Analysis.* Washington, DC: Sage Press.

Hart, J. 2013. "John Kasich: God Wants Ohio to Expand Medicaid." www.mediatrackers.org, June 18.

Hayes, W., and T. Sahr. 2014. (Adjunct Professor, and Director of Research and Analysis, respectively, Wexner Medical Center Ohio State University.) Interview by the author, March 13, 2014.

Healy, P. 2015. "Scott Walker Enters 2016 Presidential Race, Pledging Conservative Agenda." *New York Times*, July 13.

Henderson, M., and J. Shepherd. (Associate Vice President of Government Contracts [Henderson] and Lobbyist [Shepherd].) Interview by the author, March 7, 2014.

Holahan, J. et al. 2012. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis.* Washington, DC: Kaiser Family Foundation.

HPIO (Health Policy Institute of Ohio). Ohio State University (OSU), Regional Economic Models, Inc., and the Urban Institute). 2013. "Expanding Medicaid in Ohio: Analysis of Likely Effects."

Jacobs, L., and T. Callaghan. 2013. "Report on Health Reform Implementation: Why States Expand Medicaid: Party, Resources, and History." *Journal of Health Politics and Law* 30, no. 5 (October):1023–50.

Jacobs, L., and T. Skocpol. 2012. *Health Care Reform and American Politics*, 2nd ed. New York: Oxford University Press.

Jacobs, L., and T. Skocpol. 2013. "Progressive Federalism: The Implementation of Health Care Reform." In *Politics of Major Policy Reform*, edited by J. J. Milkis. New York: Cambridge University Press.

Johnson, B. (Associate Director, National Alliance on Mental Illness, Ohio.) Interview by the author, March 13, 2014.

Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission). 2012. "A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage." http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8349.pdf.

Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission). 2013. "The Role of Medicaid in State Economies and the ACA: Issue Brief." KFF.org. https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf.

Karol, D. 2009. *Party Position Change in American Politics: Coalition Management.* Cambridge, UK: Cambridge University Press.

Kasich, J. 2010. "Kasich Taylor for Ohio: Obamacare Must Be Blocked." https://www.kasichforohio.com/john-kasich-obamcare-must-be-blocked/.

Kasich, J. 2013. "State of Ohio Executive Budget Fiscal Year 2014–2015." http://media.obm.ohio.gov/OBM/Budget/Documents/operating/fy-14-15/bluebook/budget/Budget_14-15.pdf.

Kasich, J. 2013, February 2. *State of the State Address.* Retrieved from Office of the Governor of Ohio: www.governor.ohio.gov/Portals/0/2013%20State%20of%20the%20State%20Transcript.pdf

KFF (Kaiser Family Foundation). 2010. *Summary of Health Care Provisions under the Patient Protection and Affordable Care Act* (#8023-R).

KFF (Kaiser Family Foundation). 2011. *Kaiser Family Foundation*. Retrieved 2014, from Health Coverage and Uninsured Indices: http://kff.org/other/state-indicator/total-population/.

KFF (Kaiser Family Foundation). 2013. *Medicaid Fact Sheet—The Medicaid Program at a Glance*. https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7235-061.pdf.

KFF (Kaiser Family Foundation). 2013. "State Decisions on Health Insurance Exchanges and the Medicaid Expansion, as of September 3, 2013." kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-the-Medicaid-Expansion-as-of-September-3-2013.

King, N. 2013. "An Ohio Prescription for GOP: Lower Taxes, More Aid for Poor—Gov. John Kasich Promotes Blend of Conservative Orthodoxy Leavened with Liberal Politics." *Wall Street Journal*, August 14.

Kousser, T. 2014. (Associate Professor, University of California, San Diego.) Interview by the author, January 20, 2014.

Kousser, T., and J. Phillips. 2012. *The Power of American Governors.* New York: Cambridge University Press.

Lachman, S. 2014. "Tea Party Leader Ted Stevenot Decides not to Challenge John Kasich." *Huffington Post*. www.huffingtonpost.com/2014/01/06/ted-stevenot-ohio_n_4549687.html (accessed January 6, 2014).

Legislative Fiscal Bureau. 2013. "BadgerCare Plus—Eligibility (DHS—Medical Assistance and Related Programs): Joint Committee on Finance Paper #321." Madison: Legislative Fiscal Bureau.

Levine, C. 2014. (Executive Director, Universal Health Care Action Network Ohio.) Interview by the author, March 10, 2014.

Lipton, E. 2011. "Billionaire Brothers' Money Plays Role in Wisconsin Dispute." *New York Times*, February 21. www.nytimes.com/2011/02/22/us/22koch.html?_r=2&pagewanted=all&.

Maglione, T. 2014. (Lobbyist, Ohio State Medical Society.) Interview by the author, March 10, 2014.

Martin, C., and D. Swank. 2004. "Does the Organization of Capital Matter?" *American Political Science Review* 98, no. 4: 593–612.

Martin, J. 2013. "Health Law Is Dividing Republican Governors." *New York Times*, November 11.

Mayhew, D. 1974. *Congress: The Electorate Connection.* New Haven: Yale University Press.

Mayhew, D. 2001. "Observations on 'Congress: The Electoral Connection' a Quarter Century after Writing It." *Political Science and Politics* 34, no 2 (June): 251–52.

McCarthy, J. 2014. (Director, Ohio Department of Medicaid.) Interview by the author, March 12, 2014.

Moody, G. 2014. (Director, Office of Health Transformation.) Interview by the author, March 28, 2014.

Moore, K. 2014. (Deputy Secretary, Health Services.) Interview by the author, March 5, 2014.

Moran, C. 2014. (Chief of Staff: Representative Jon Richards [D]). Interview by the author, March 3, 2014.

Mukherjee, S. n.d. "Anti-Obamacare Governor Now Encouraging Residents to Enroll under Health Law." www.thinkprogress.com (accessed March 24, 2014).

National Federal of Independent Business v. Sebelius, Secretary Health and Human Services, No. 11–393, United States Supreme Court, June 28, 2012.

Ohio Attorney General's Office. n.d. "Ballot Initiative and Referendum Processes." OhioAttorneyGeneral.Gov. www.ohioattorneygeneral.gov/Legal/Ballot-Initiatives (accessed April 8, 2014).

Ohio Office of Budget and Management. "About the Controlling Board." Ohio State Controlling Board. www.ecb.ohio.gov/public/About.aspx (accessed April 8, 2014).

Oliver, T. 2014. (Professor, Population Health Sciences, University of Wisconsin.) Interview by the author, March 6, 2014.

Olson, L., and L. Davidson. 2014. (Directors, Wisconsin Primary Care Association.) Interview by the author, March 5, 2014.

OnTheIssues.com. n.d."Scott Walker on the Budget and Economy." www.ontheissues.org/Scott_Walker.htm#Budget_+_Economy (accessed February 3, 2014).

Oshifski, D., and R. Cunningham. 2008. *Agendas and Decisions: How State Government Executives and Middle Managers Make and Administer Policy.* Albany: State University of New York Press.

Peacock, J. 2014. (Research Director, Wisconsin Council for Children and Families.) Interview by the author, March 4, 2014.

Peters, M., and L. Radnofsky. 2013. "A Medicaid Bet in Wisconsin." *Wall Street Journal*, December 18.

Phillips, J. 2013. "Public Opinion and Morality." In *Politics in the American States: A Comparative Analysis*, edited by V. Gray, R. Hanson, and T. Kousser, 436–69. Washington, DC: Sage.

Pierson, P. 1995. "Fragmented Welfare States: Federal Institutions and the Development of Social Policy." *Governance: An International Journal of Policy, Administration, and Institutions* 8, no. 4: 449–78.

Prah, P. 2013. "Five Years After Crash: States Still Picking Up Pieces." Pew Charitable Trust: Stateline Report. www.pewstates.org/projects/stateline/headlines/five-years-after-crash-states-still-picking-up-pieces-85899502301.

Reimer, D. 2014. (Senior Fellow, WI Public Policy Institute.) Interview by the author, February 28, 2014.

Rogowski, R. 2010. "How Inference in the Social (and Not the Physical) Sciences Neglects Theoretical Anomaly." In *Rethinking Social Inquiry*, edited by H. Brady and D. Collier, 89–99. Plymouth, UK: Rowman and Littlefield Publishers.

Rohling McGee, A. 2014. (President, Health Policy Institute of Ohio.) Interview by the author, March 12, 2014.

Rom, Mark Carl. 2013. "State Health and Welfare Programs." In *Politics in the American States: A Comparative Analysis*, edited by V. Gray and R. H. Kousser, 339–74. Washington, DC: Sage.

Rosenbach, M. et al. 2003. *Implementation of State Children's Health Insurance Program: Synthesis of State Evaluations: Background for the Report to Congress.* Cambridge, MA: Mathematica.

Rosenbaum, S., and T. Westmoreland. 2012. "The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?" *Health Affairs* 31, no. 8: 1663–72.

Rude, N. 2014. (Representative John Nygren [R] Staff.) Interview by the author, March 7, 2014.

Saelens, H., and J. Robertson. 2014. (Vice President, Government Contracts [Saelens] and Director, Government Contracts [Robertson], Molina Health Care Ohio.) Interview by the author, March 11, 2014.

Sargent, G. 2012. "Tea Party Group Goes All In to Save Scott Walker." *Washington Post*, February 8.

Sears, B. 2014. (Ohio State Representative [R].) Interview by the author, March 11, 2014.

Seiber, E. 2014. (Associate Professor, Health Services Management and Policy, Ohio State University.) Interview by the author, February 10, 2014.

Shepherd, J. 2014. (Lobbyist, Molina Health Plans of Wisconsin.) Interview by the author, March 7, 2014.

Singer, S. 2012. "David Koch Intends to Cure Cancer in His Lifetime and Remake American Politics." *Palm Beach Post*, February 20.

Skocpol, T. 2013. "The ObamaCare Challenge: Partisan Conflict and the Implementation of a Nationwide Reform in Fifty States." Wildavsky Lecture, presented at the Berkeley, CA School of Public Policy, April 4.

Springer, M. 2012. State Electoral Institutions and Voter Turnout in Presidential Elections, 1920–2000. *State Politics & Policy Quarterly* 12: 252–83.

Stein, J. 2014. (Journalist, Milwaukee Sentinel.) Interview by the author, March 3, 2014.

Stein, J., and P. Marley. 2013. *More Than They Bargained For.* Madison: University of Wisconsin Press.

Stonecash, J. 1996. "The State Politics Literature: Moving beyond Covariation Studies and Pursuing Politics." *Polity* 28, no. 4 (Summer): 559–79.

Thelan, K. 2001. "Varieties of Labor Politics in the Developed Democracies." In *Varieties of Capitalism*, edited by Peter A. Hall and David Soskice, 71–103. New York: Oxford University Press.

Truman, D. 1951. *The Governmental Process: Political Interests and Public Opinion.* New York: Alfred Knopf.

Vogel, D. 1996. "Why Businessmen Distrust Their State: Political Consciousness of American Corporate Executives." In *Kindred Strangers: The Uneasy Relationship between Politics and Business in American*, 29–72. Princeton, NJ: Princeton University Press.

Walker, S. 2012. "Op-Ed: Obamacare Is an Unhealthy Prescription." *Washington Post*, July 12.

Walker, S. 2013. "State of Wisconsin Budget Address." Madison, WI.

Wall Street Journal. 2013. "Medicaid and the Apostle Kasich: The Ohio Governor's Lawless, Faith-Based Obamacaid Expansion." Opinion, October 22.

Weil, A. 2014. (Executive Director, National Academy of State Health Policy.) Interview by the author, March 20, 2014.

Whalberg, D. 2014. (Journalist, Wisconsin State Journal.) Interview by the author, March 7, 2014.

Whitesides, J. 2012. "Walker's Win in Wisconsin Boosts Conservatives." *Reuters*, February 6.

Wisconsin Government Accountability Board. 2014. "Campaign Finance Limits and Deadlines." http://gab.wi.gov/campaign-finance/limits-deadlines. (accessed March 31, 2014.)

Wisconsin State Government. 2014. Wisconsin State Assembly. http://legis.wisconsin.gov/Pages/asmhome.aspx.