Dynamic Federalism and the Implementation of the Affordable Care Act[1][2]

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Abstract

Political maneuvering over health care reform continues and will likely persist. The reality, however, is that health reform is now proceeding in Washington and in states across the country after the Supreme Court's affirmation of the Affordable Care Act of 2010 (ACA) and President Barack Obama's reelection. The pace and scope of health reform is, however, varying across states. This paper investigates four potential explanations for the variation in state decisions to implement the Medicaid expansion – state party control, economic affluence, the trajectory of established policy, and the process of learning about intergovernmental bargaining. Our analysis of 50 states finds that party control is a dominating influence on state decisions; but economic affluence and process learning impacted states with Democratic governors. The findings suggest that while party casts a long shadow over states, states that extensively interact with federal agencies develop skills and expectations to treat new programs from Washington as an opening bid subject to negotiation rather than as a fixed "take-it-or-leave-it" proposition. The paper concludes by underscoring the value of moving beyond partisanship to explore additional influences including the lasting effects of state interaction with federal policy making.

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Political maneuvering over health care reform continues and will likely persist. The reality, however, is that health reform is now proceeding in Washington and in states across the country after the Supreme Court's affirmation of the Affordable Care Act of 2010 (ACA) and President Barack Obama's reelection. Republican efforts to "repeal" the ACA in Washington and to blunt it in states are sowing some confusion among consumers but not stopping the wheels of implementation (Ario and Jacobs 2012).

The pace and scope of health reform is, however, varying across states. The ACA's expansion of access to medical care rests on two programs: the establishment of health insurance exchanges for individuals and small businesses without coverage and the expansion of Medicaid to all individuals below 138 percent of the federal poverty line. The exchanges will be established throughout the country; the federal government will establish exchanges in states that decide not to act.

The greatest differences across states will emerge with regard to Medicaid reform as some states exercise their option not to proceed. The Supreme Court's ruling in June 2012 upheld the constitutionality of the ACA and its exchanges but made the Medicaid expansion optional and, specifically, barred Washington from using the threat of withholding existing funding as a stick to pressure state compliance. While the federal government cannot cut funding, the ACA is offering states generous carrots – it will pay 100% of the costs from 2014-2016 and then 90% of the costs after 2020 as well as a generous portion of administrative expenses. The fiscal weight on state budgets for paying for the "uncompensated care" of the uninsured can now be considerably lightened. Although fiscal carrots are inducing some states to proceed to expand Medicaid, about half the states are not moving ahead with reform.

The ACA's reform of Medicaid raises an important question for health reform as well as the nature of intergovernmental relations: What is influencing state decisions to implement the Medicaid expansion? Of course political party is a major explanation – states where Republicans enjoy all or some levers of power are tending not to proceed while Democratic controlled states are generally implementing the expansion more rapidly and thoroughly. As important as political party looms, it is not sufficient as evident from the variations in progress among Democratic and Republican states.

This paper argues that "dynamic federalism" is a critical factor in influencing the degree of state progress on health reform, raising broader issues about intergovernmental relations. In the broad field of federalism, most analysis focuses on comparative state analysis and on the one-way relationship of the national government to the states or vice-a-versa. Neglected is how state interactions with Washington produce "*process learning*" that new federal programs are opening preludes to negotiations for states to widen discretion to fit their contexts instead of a once and final demand. We argue that state decisions to implement ACA's expansion of Medicaid are, in part, a function of longstanding experiences with the federal government: state experience negotiating and working with the Centers for Medicare and Medicaid (CMS) in the Department of Health and Human Services (DHHS) builds up the skill and confidence to treat interactions with the national government as a dynamic balancing of national regulations and state preferences. States with more experience interacting with CMS over Medicaid changes are expected to make particular progress implementing ACA's expansions because they have learned the skills and appropriately modulated expectations to effectively bargain with Washington. Conversely, states with less of a track record interacting with CMS are more likely

to view federal rules relating to the ACA as fixed rather than negotiable and, as a result, make less progress implementing the new Medicaid expansions.

This paper begins by situating state decisions on Medicaid expansion within scholarly debates over federalism and intergovernmental relations before discussing our data and analyses.

STATE LEARNING ABOUT INTERGOVERNBMENTAL RELATIONS

The study of federalism often focuses on the horizontal relations across states. For instance, research on the diffusion of policy innovations among states is one of the most widely studied components of horizontal federalism (Gray 1973; Mooney and Lee 1995; Pancheco 2012).

The intergovernmental relations between state and national governments took off with the New Deal's expansion of Washington's responsibilities and fueled research on two types of vertical federalism – downward and upward. Downward federalism is the national government's use of strong, clear mandates and mix of rewards and punishments to drive state action on policies as diverse as health care, education, and environmental protection (Karch 2006; Roh and Haider-Markel 2003; Allen, Pettus, and Haider-Markel 2004). Activity by the national government and Congress not only impacts policy but also stimulates political reactions including the mobilization of interest groups (Baumgartner, Gray, and Lowery 2009).

Upward federalism traces back to the notion of states as "laboratories of democracy," which generate ideas and policy innovations that "rise" up to drive national policy making (Brandeis 1932). Although widely heralded, research generally points to the limited scope of direct state influence on specific Washington policies (Robertson 2012 173-5; Weissert and Scheller 2008 171; Thompson 2012).

Much of the discussion of intergovernmental relations focuses on tracing the "pendulum" swings between upward and downward federalism. For instance, Robertson (2012) traces the see-sawing of authority to the federal level in the 1930s back toward the states in the 1970s and 1980s before the surge of nationalization in K-12 education and health care in the early 21st century.

Less attention, however, has been devoted to the dynamic nature of intergovernmental relations and, specifically, how state learning from their history of interacting with Washington can influence their receptivity to new federal policies. The most commonly studied form of intergovernmental learning concentrates on "*policy learning*." Policy learning occurs both in horizontal federalism (i.e. states or cities study evidence to identify successful policy adoptions by counterparts)[3] and in vertical federalism where the national government follows state policies that work (Weissert and Scheller 2008). The key feature in both forms of policy learning is that past experiences and policies influence future action. The limitation with the "policy learning" concept is that it neglects state experiences, skills, and expectations about the opportunities and constraints of the process of intergovernmental relations.

"Process learning" results from the knowledge and experience that states pick up from bargaining and negotiating with Washington. States learn through the iterative sequence of the intergovernmental process – the national government's initial activity, the state requests for modifications or exemptions, and Washington's subsequent requests for revisions and then approval. The gain is mutual: federal agencies can induce participation and innovation from states that might otherwise resist or refuse new programs; the states can reap greater latitude to shape national policy to their circumstances. States that effectively engage in the

[3] Shipan and Volden 2008; Kile 2005; Berry and Berry 1990; Glick and Hays 1991; Gray 1973; Mooney 2001; Mooney and Lee 1995 and 2000; Walker 1969.

intergovernmental bargaining process tend to develop expectations that federal agency implementation of laws are somewhat malleable (rather than rigidly fixed) and pick up skillful strategic tools – from lobbying Congress or the executive branch for changes or greater flexibility in policy to coalition building with legislators and organized groups who can pressure government officials. In addition to positive inducements that flow from bargaining, states also witness the costs of inaction – missed opportunities from not modifying new mandates, the politically damaging criticism from organized stakeholders, and internal pressure from disgruntled program officials.

State "process learning" from past relations with the national government is especially likely with regard to federal health policy and Medicaid because of repeated, routinized, and longstanding intergovernmental interactions. Medicaid's federal administrator – the Centers for Medicare and Medicaid (CMS) – operated a process for states to seek waivers to experiment with Medicaid; this produces (from certain states) a large and steady stream of requests backed up by lobbying of Congress, DHHS, and the White House, which in turn resulted in a string of federal requests for modifications and then approvals (Thompson and Burke 2007). The back-and-forth between Washington and the states over the amending of Medicaid through waivers (as authorized through Section 1115 of the Social Security Act) created a process in which bargaining and mutual accommodations (including re-interpretations of what Congress passed into law) became the "norm" (Shelly 2013; Kim and Jennings 2012). State submission of requests for Section 1115 waivers are often preceded and then followed by extensive and time consuming negotiations with the federal government, not infrequently taking several years to obtain approval. States that regularly and effectively pursued Section 1115 waivers learned both skills for influencing the federal government's program evaluation and decision making across

the executive and legislative branches as well as modulated expectations – the opportunities for greater flexibility and the limits to what CMS will accept (Thompson and Burke 2007; Weissert and Weissert 2008).

NESTED FEDERALISM: EXPLAINING MEDICAID EXPANSION

Process learning may guide state responses to federal policy within political, policy, and economic contexts

Partisanship and State Policy Making

A common account of vertical federalism is that state adoption of federal programs is a function of the national government's provision of funding and latitude. As Gormley (2006) puts it, "[t]he more money the federal government makes available to the states [and the fewer mandates], the happier the states tend to be" (525; also Allen, Pettus, and Haider-Markel 2004; Karch 2006).

While money and institutional latitude are certainly attractive features for states, the political salience of the program is a conditioning factor. Programs that become highly visible in polarized party disputes are conditions that will entirely over-ride or significantly offset the financial and institutional attractions of a new federal program.

The impact of partisanship is amply evident in state decision making on implementation of the ACA's Medicaid expansion. On the one hand, the financial incentives are exceptional. Washington covers all the costs of expansion for the first three years and, afterward, continues to cover an unusually large portion of Medicaid costs. As a general rule, the federal government pays 55% of Medicaid's costs to states; ACA offers to cover all costs for the first three years and then 96 percent of administrative and benefit costs as well as to reduce state funding for "uncompensated care" of the uninsured whose treatments will be covered by the new program

(Conlan and Posner 2011; Angeles 2010; Kaiser Family Foundation 2010; Bachrach and Jacobs 2012). In addition, the adoption of the Medicaid expansion is not mandated; it is an option. On the other hand, the sharp partisan divide during the passage of ACA in 2010 (no Republicans voted for its passage) has persisted afterward (Rigby and Haselswerdt 2013; Jacobs and Callaghan 2013; Oberlander 2011; Jones, Bradley and Oberlander 2012; Francis and Francis 2010). Most of the states controlled by Democrats -- like Connecticut, Maryland and Minnesota – adopted the expansions of Medicaid while the majority of Republican controlled states are refusing to implement it. (21 of 30 Republican governors are opposing the reform while all of their Democratic counterparts are support it.)

The mediating effects of partisanship on state evaluation of the ACA's financial and institutional features are, however, not uniform (Jacobs and Callaghan 2013). A large number of states where Democrats hold power not yet enacted the Medicaid expansion. Perhaps more surprising, a number of Republican states like Arizona, Iowa, New Mexico and North Dakota departed from the partisan norm and implemented reform. Conservative favorite, Jan Brewer (Republican Governor of Arizona), bullied the state legislature's more conservative Tea Party members into adopting it by insisting that "It's pro-life, it's saving lives, its creating jobs, it is saving hospitals…I don't know how you can get more conservative than that" (quoted in Santos 2013).

Explaining State Variation in Implementing the ACA's Medicaid Expansion

Given the federal government's generous financial and institutional offer, what might explain the variations in state implementation of Medicaid expansions after controlling for party control? Three factors stand out. First, the degree of state process learning may factor in how states evaluate the ACA's terms. States with more extensive experience working with CMS on

1115 waiver requests may be more receptive (than those with less interaction) to pursue Medicaid in the expectation that they can tailor it, to some extent, to their circumstances while capitalizing on the new resources.

The scope and nature of each state's existing Medicaid program may be a second factor influencing its evaluations of the ACA's invitation to expand it. Studies of American political development and policies ranging from education to Social Security and assistance for the poor show that established policy creates "self-reinforcing or positive feedback[s]" that perpetuate and often lead to the expansion of the programs (Pierson 2000; Orren and Skowronek 2004; Campbell 2003; Skocpol 1992; Mettler and Soss 2004). This body of research suggests that state decisions about ACA's Medicaid expansion will be driven by prior state policies related to Medicaid eligibility and benefits for the poor and the uninsured.

A third potential influence on state adoption of ACA's Medicaid expansion is its economic circumstances. Most research suggests that affluence states are more innovative and receptive to developing new federal initiatives (Welch and Thompson 1980; Rigby and Haselswerdt 2013; Davies and Derthick 1997, pp. 229-31)). Less well-off states may find even generous federal matches to be burdensome. This pattern of results from past research contradicts the predictions of some supporters of reform -- that less affluent states may especially welcome Medicaid reform because of its generous terms (Bachrach and Jacobs 2012). Indeed, the ACA's attractive financial offer to states was designed by Democratic lawmakers precisely to make it "too good" to pass up especially as states were emerging from the economic collapse of 2009 and hungry for federal dollars to add to its Medicaid coffers. .

Research on federalism points to four hypotheses to explain state variation in Medicaid expansion.

- *Partisan polarization*: The greater control of state government by the Democratic Party is expected to be closely related to progress expanding Medicaid; conversely, Republican control is anticipated to coincide with less progress.
- *State Economic Circumstances*: More affluent states are expected to be particularly prone to accept federal funds and to implement reform while less affluent states will feel constrained from expanding Medicaid by their difficulty to pay even modest additional costs.
- *Policy Trajectory*: States with a history of establishing programs for the vulnerable and changing benefits to become more generous are expected to be predisposed to adopt ACA's expansion of Medicaid.
- *Process Learning*: More extensive state "process learning" about intergovernmental bargaining (as measured through the extent of Section 1115 waiver requests) is expected to be associated with greater progress in achieving reform.

DATA AND ANALYSIS

We have collected the data and constructed four variables across 50 states to analyze the four hypotheses for state Medicaid expansion.

Relative State Progress Expanding Medicaid

Developing a measure of relative state progress expanding Medicaid (our dependent variable) is a particular challenge. Most efforts to track state decision making rely on a trichotomous measure that records whether states are moving forward with reform, not moving forward with reform, or if debate is still ongoing in the state. The Kaiser Family Foundation, for example, uses this approach and reports that 23 states are moving forward with reform, 21 are not moving forward and that 6 are undecided. The limit of this approach is that it omits data on

relative state progress – the progress of states in planning for the expansion but not formally enacting them as well as those that have enacted them but lagged in developing the necessary infrastructure.

Unfortunately, the extensive work developing measures of Medicaid development prior to the ACA's passage is not well-suited to studying its initial implementation. Relative state adoption of ACA is not tracked by past measures of the generosity of Medicaid benefits (Moffit, Ribar and Wilhelm 1998; Buchanan, Cappelleri, and Ohsfeldt 1991), the dimensions of Medicaid's political dynamics (Grogan 1994; 1999) and other approaches. Rigby and Haselswerdt (2013) develop a new measure to track ACA implementation (focusing on insurance exchange adoption by states) based on the differences among states in the length of time taken to enact reforming; but this approach neglects the content of reform.

We develop an alternative measure of state implementation of ACA's Medicaid extension that focuses on relative state progress in moving through four ordered stages of development toward greater compliance with federal requirements. The first stage is state submission to CMS of an "advanced planning document" (APD) to upgrade Medicaid's eligibility system to comply with new ACA requirements. Taking this step indicates that the state is complying with a core requirement of ACA that will improve the quality of eligibility system determination and is not, in practice, defying federal law. The second stage is state receipt of at least one "Level One" federal grant to finance planning for implementation. The application process for obtaining these grants requires a concerted effort from state government to detail how it will use federal funds to comply with the ACA. Data for the first two stages of reform are compiled by the federal government.[4]

[4] The data can be found here: http://kff.org/medicaid/state-indicator/medicaid-chip-eligibility-systems/ http://www.cms.gov/cciio/resources/marketplace-grants/index.html

While submitting APDs and receiving a federal planning grant indicate a general intent to prepare for reform and identify options, the third level moves toward actual state approval of the Medicaid expansion – the Governor's public announcement of support for the reform. Gubernatorial support for reform is a necessary (though not sufficient) step because the executive branch takes the initiative for planning and the approval of the state's chief executive is required to sign enacted legislation into law. Because governors tend to focus on the ACA's attractive financial and institutional terms as well as the broad pressure behind reform from stakeholders in the health care system, their support has been more forthcoming and vocal than the legislature's. A number of governors were supportive of Medicaid expansion but stymied by legislators (e.g. Michigan, Ohio, Missouri, Florida, and Montana). Gubernatorial support is tracked through public statements in State of the State addresses, press releases, and other speeches in conjunction with the monitoring by Kaiser Health Facts and The Advisory Board. The final and most difficult stage is legislative enactment of a bill to authorize Medicaid expansion. While the governors in 29 states publicly expressed support for reform, only 16 of the legislatures passed authorization. State scores track relative progress toward implementation by measuring the completion of each stage of development, ranging from 4 for adoption of the new program extensions to zero if no progress is evident. (See Appendix for more detailed information.)

Our measure of state Medicaid expansion, which is presented in Figure 1, reveals substantial variation among states. As expected, state progress is heavily influenced by partisanship with progress most pronounced among the Democratic-controlled states of California, Colorado, Massachusetts, and Minnesota and the least progress occurring in the Republican states of Texas, South Carolina, and Louisiana. What is also apparent, however, is

the variation that defies a rigid partisan pairing of states. Some states defy the partisan pattern as illustrated by the Medicaid approval by the Republican-controlled Arizona, North Dakota, and New Jersey, where Governor Chris Christie vetoed stand-alone legislation before signing it into law as part of a larger budget bill. Just as striking is the relative progress (short of adoption) by the GOP states of Florida, Michigan, and Ohio and by the divided government of Kentucky.

Our measure reflects developments as of June 2013 and therefore should be considered interim findings. Some states (such as Oregon, Hawaii and Nevada) are likely to enact the reform but have not yet done so and others (like Arkansas and Iowa) have met our coding rules because they authorized the Medicaid expansion and are currently negotiating with CMS for a waiver to experiment with a "premium support" model of using new federal Medicaid funding to help beneficiaries to purchase private coverage on the new insurance exchange.[5]

[Insert Figure 1 About Here]

Independent Variables to Explain State Medicaid Reform

We construct four independent variables to explain state variation in Medicaid reform. The first is "process learning" by states, which is based on the total number of Section 1115 Medicaid waivers requested by each state using information collected by CMS and supplemented by information since 2010 gathered by Kaiser Health Facts. In total, states requested 90 waivers between 1993 and 2013, ranging from zero proposals by New Hampshire and South Dakota to a high of five waivers filed by Wisconsin.[6]

[5] Vermont continues to be a leader of health reform but does not meet our coding rules for authorizing Medicaid expansion: the Democratic Governor announced that new legislation is not necessary because the state's current program already meets ACA's requirements. In addition to our independent tracking, our coding draws on reports from Kaiser and the Advisory Board, which can be found here: http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ and http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/

[6] Our identification of 90 Section 1115 waivers is a more conservative, readily replicated count based on CMS and Kaiser than the 195 waivers filed by 1998 that Thompson and Burke's (2007) identified. It was difficult to update

The second variable is political party control of state government and is measured by an additive measure in which scores increase based on wider Democratic control of the governor's office and the chambers of the state legislature. Full Democratic control of state government is scored as 6 points, a Democratic governor and Democratic control of one legislative chamber is 4 points, Democratic control that is limited to one legislative branch is 3 points. When the number of legislators in a single chamber is evenly split between the parties (as in the case of Virginia), the state receives 1 point; no points are given for unified Republican control. The third variable accounts for the economic circumstances of states based on per capita income. This measure uses population data from the 2010 Census and state-level personal income data which is averaged over all four quarters of 2010, which is provided by the Bureau of Economic Analysis.[7]

The fourth independent variable is existing Medicaid policy. We developed an additive scale to measure the existence and generosity of state programs toward pregnant women, working parents, the medically needy, childless adults and to more than 90 percent of children (84.8 percent are covered, on average, through SCHIP as of 2009). (A detailed description can be found in the Appendix.)

EXPLAINING RELATIVE STATE EXPANSION OF MEDICAID

Our multivariate analyses examine the impacts on state Medicaid expansion by four potentially significant influences -- state party control, economic affluence, established policy trajectory, and policy learning through waiver requests. We use ordinal logistic regression

reliably the Thompson and Burke dataset because it relied on private communications with CMS and on a complicated search of the Federal Register. .

[7] Similar results were found for alternative variable specifications and, particularly, when we used second quarter income data.

because the dependent variable is an ordered but non-continuous variable measured along four points.

Table 1 confirms the partisan patterning of health reform that was plainly evident in Figure 1. Aside from state party control, none of the other independent variables approaches statistical significance even after we explore reduced models (Models 2, 3, and 4). These findings offer strong support for the party control expectation: the stronger the Democratic control over state government, the more progress the state makes in implementing Medicaid reforms.

Although these findings are consistent with new research on ACA implementation (e.g. Jacobs and Callaghan 2013; Rigby and Haselswerdt 2013), they modify past research on vertical federalism that treated state adoption as a function of financial and institutional attractiveness (Gormley 2006; Allen, Pettus, and Haider-Markel 2004; Karch 2006). In the context of pervasive and intense partisan polarization, intergovernmental relations have become conditional on whether relations become visibly defined in partisan terms.

[Insert Table 1 About Here]

Nonetheless, what explains variations among Democratic states and among Republican states? After all, Figure 1 shows that Medicaid progress varies noticeably within each cluster of states.

We investigate the effects of additional influences by splitting the dataset by party and by analyzing the effects of all of our independent variables with the exception of party control on the 20 states with Democratic governors and the 30 states with GOP governors. Splitting the dataset reduces the degree of variation across the dependent variable while still preserving significant differences: even in the Democratic subset where every governor publicly supports

reform, almost half of the states have yet to pass relevant legislation. We use binary logit because the dependent variable is dichotomous; these analyses are restricted to states with Democratic governors – all of whom score 3 or 4 in Figure 1 and were coded as a binary measure. (Similar results are produced with the original variable constructions and ordinal logistic regression).

Our analyses of Medicaid reform in the Democratic states finds striking evidence of the effects of policy learning. Table 2 shows that state experience filing waivers and state affluence are both positive and significant predictors of reform in Democrat led states (Models 5 and 6). The positive effect of affluence confirms the expectation that wealthier states would be more prone to adopt financially and institutionally attractive federal offers; well-off Democratic states like Connecticut and Massachusetts are moving further and faster with implementation than less well-off states like West Virginia, which may be especially sensitive to even modest (real or anticipated) additional costs associated with the expansion of Medicaid. This contradicts the predictions of some supporters of reform that less affluent states may especially welcome Medicaid reform because of its generous terms. There is no evidence of the impact of established policy trajectory.

The most theoretically striking finding is the policy learning effect. The results confirm our expectation that sustained intergovernmental relations impacts states. States with more extensive experience with waiver requests (scoring at the highest end of our scale) were also the Democratic states (such as Arkansas, Minnesota, New York, and others) that were farther along adopting Medicaid reform.

[Insert Table 2 About Here]

The consistent and significant evidence of the impacts of policy learning and state affluence on progress implementing Medicaid in states with Democratic governors is not present in states with Republican governors. In particular, no statistically significant results emerge from running the models presented in Table 2 on states with Republican governors. At this point, partisanship remains dominant. These findings, however, may change over time; a substantial number of Republican governors publicly or private support Medicaid expansion (as Governor Brewer argued) to relieve fiscal and stakeholder pressure. If CMS approves the waiver request for "premium support," this may open the door for Republican states to implement Medicaid reform. In addition, elections may create greater receptivity to reform in current GOP states owing to the arrival of new Republican leaders or the election of Democrats in their place.

Discussion and Implications

State adoption of new Medicaid expansions called for under ACA is substantially driven by which political party controls government. As important as party remains in the early phrase of ACA implementation, there appears to be other dynamics at work that may grow over time (Jacobs and Callaghan 2013).

This paper finds evidence that state economic circumstances and process learning influenced Medicaid adoption in states with Democratic governors. The process learning effects among Democratic states are theoretically noteworthy, highlighting that state experience with intergovernmental relations and negotiating with federal agencies can produce skills and expectations that facilitate future state and federal receptivity to negotiation and mutual accommodation.

While the policy learning effect points to an influence on "upward federalism" when states evaluate federal policies, these findings stem from a form of dynamic, two-way vertical

federalism. State requests for 1115 Medicaid waivers – and other mechanisms for requesting flexibility – trigger back-and-forth consultations and negotiations with mutual benefits. Federal agencies (as in the case of ACA) find the bargaining useful as a way to induce state participation while states welcome opportunities to gain greater leeway than was outlined in the original law. States with extensive experience requesting and receiving waivers develop expectations of federal programs (such as the new options to expand Medicaid) as an opening bid in subsequent negotiations rather than a "take-it-or-leave-it" order to states. Strikingly, states adopting the new Medicaid expansions engaged in extensive informal consultations with federal officials and trusted intermediaries to identifying areas of flexibility as well as formal waiver requests to negotiate still greater latitude (as in the case of Arkansas).

CONCLUSION

The rapidly evolving nature of ACA implementation presents challenges to analysis. The particular set of states adopting Medicaid expansion seems more likely to grow than to contract and the prospect of intergovernmental bargaining that alters the ACA's original intent seems quite possible. Even at this interim stage, several findings with broader implications for vertical federalism may be emerging.

The tendency of past federalism research to focus on the financial and institutional terms offered by the federal government may need qualifying in an era of pervasive, intense partisan polarization. Our analysis suggests that state latitude and exceptionally generous financial terms were not adequate to offset Republican Party opposition to the ACA. Other federal programs that gain salience among partisans (such as the spending of stimulus funds) may face similar obstacles. Party control, however, should be treated as a condition rather than a fixed rule –

federal programs that competitively supply grants to fund innovation in K-12 education are attracting both Democratic and Republican states.

Even as partisanship casts a shadow over state and federal policy making, there continues to be substantial variation in state decisions that is not explained by party alone. The Medicaid expansions by Republican governors in Arizona, New Jersey, and elsewhere points to influences that counteract party. Over time, more Republican governors may find the pull of party increasingly cross-pressured by a variety of factors -- from policy learning and the state's administrative capacity to the lobbying of organized stakeholders representing businesses, medical providers, and patients.

As the implementation of ACA proceeds beyond 2014, we may find that the initially dominant pull of political party gives way to a fuller range of influences as a widening swath of constituents benefit from health reform.

Figure 1: Medicaid Reform Development

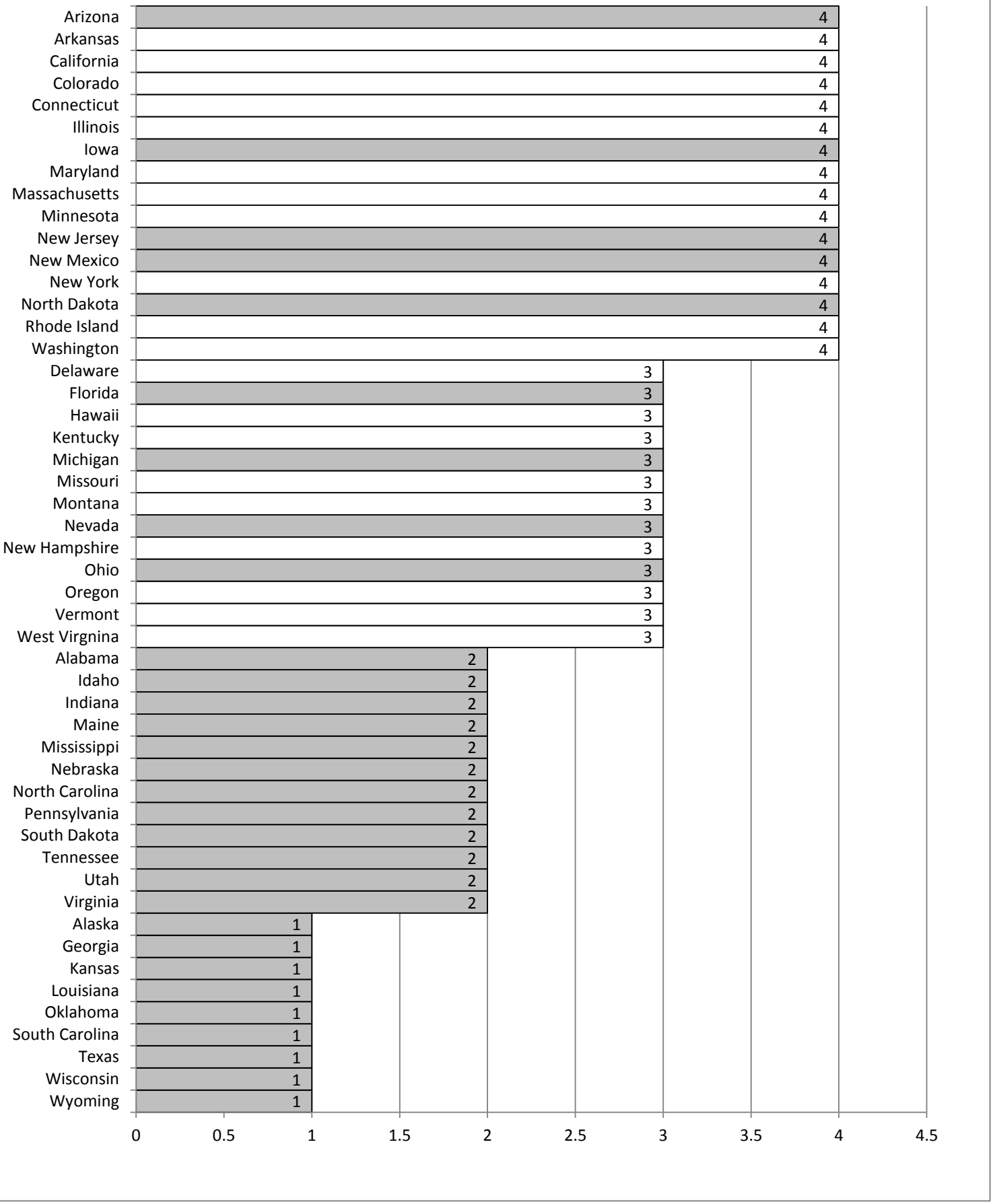

Table 1: Party Control Dominates State Decision Making on Medicaid Expansion
(The dependent variable is state adoption of ACA's Medicaid Expansion)

VARIABLES	(Model 1)	(Model 2)	(Model 3)	(Model 4)
Party Control	0.556***	0.576***	0.588***	0.567***
	(0.157)	(0.148)	(0.358)	(0.337)
Waivers Prop.	0.275	0.291	0.227	
	(0.272)	(0.266)	(0.266)	
Affluence	0.00006	0.00007		0.00005
	(0.00006)	(0.00005)		(.00006)
Med. Trajectory	0.048		0.083	0.069
	(0.123)		(.117)	(0.120)
Observations	50	50	50	50
Pseudo R-squared	0.2292	0.2281	0.221	0.2216

Note: Ordinal logistic regression is used because the dependent variable is an ordered but non-continuous variable measured along four points.
Standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.10

Table 2: Process Learning Impacts Democratic States
(The dependent variable is adoption of ACA's Medicaid Expansion in states where the Governor is Democratic)

VARIABLES	(Model 5)	(Model 6)
Waivers Prop.	1.281*	1.244*
	(0.722)	(0.704)
Affluence	0.0004**	.0004**
	(0.0002)	(.0002)
Med. Trajectory	-0.063	
	(0.234)	
Constant	-19.742**	-19.417**
	(8.725)	(8.657)
Observations	20	20
Pseudo R-squared	0.4691	0.4664

Note: Binary logit is used because the dependent variable is dichotomous; these analyses are restricted to states with Democratic governors that score 3 or 4 in Figure 1.
Standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.10

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Appendix

Coding of Hierarchy of Medicaid Reform Development

Stage 1: APD Submission

1= Submission of advanced planning document (APD) for Medicaid eligibility system upgrade

0= No Submission of advanced planning document for Medicaid eligibility system upgrade

Source: http://kff.org/medicaid/state-indicator/medicaid-chip-eligibility-systems/

Stage 2: Level 1 Grant Approval

1= States who received a level one grant from the federal government to implement ACA reform

0= No level one grant awarded to state

Source: http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html

Stage 3: Gubernatorial Support

1= Clear indication of gubernatorial support for ACA related Medicaid reform

0= No indication of gubernatorial support for ACA related Medicaid reform including outright opposition

Sources: http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/
http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/

Stage 4: Passed Legislation Implementing Reform

1= Legislation implementing reform passed by legislature and signed by governor

2= No legislation implementing Medicaid reform has been signed into law

http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Coding of Dynamic Federalism

Dynamic federalism is an additive variable capturing the number of Section 1115 Medicaid waivers proposed by the state. If the records available through CMS and Kaiser Health Facts indicate that the state has not proposed any waivers they get a score of zero. For states that have submitted waivers, 1 point is awarded for each additional waiver proposed. The highest score for any state was 5 waivers proposed.

Sources: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html
http://kff.org/medicaid/issue-brief/an-overview-of-recent-section-1115-medicaid/

Coding of State Medicaid Policy Trajectory

Coverage for Low Income Adults

2= Medicaid benefits available for low income adults as determined by Kaiser Health Facts

1= Limited coverage for low income adults as determined by Kaiser Health Facts

0= No coverage for low income adults as determined by Kaiser Health Facts

Source: http://statehealthfacts.org/comparereport.jsp?rep=130&cat=4

Coverage for Working Parents

2= Available to working parents over 99% of the federal poverty level as determined by Kaiser Health Facts

1= Available to working parents between 50-99% of the federal poverty level as determined by Kaiser Health Facts

0= Only available to working parents below 50% of the federal poverty level as determined by Kaiser Health Facts

Source: http://statehealthfacts.org/comparereport.jsp?rep=130&cat=4

Coverage for Pregnant Women

2= Available to pregnant women over 185% of the federal poverty level as determined by Kaiser Health Facts

1= Available to pregnant women at 185% of the federal poverty level as determined by Kaiser Health Facts

0= Available to pregnant women below 185% of the federal poverty level as determined by Kaiser Health Facts

Source: http://www.statehealthfacts.org/comparereport.jsp?rep=77&cat=4&gsa=2

Medicaid Payments per Enrollee (States awarded points by quartile)

3 points = States with Medicaid payments per enrollee between the 75th and 100th percentile for fiscal year 2009 (Most recent year available from Kaiser Health Facts)

2 points = States with Medicaid payments per enrollee between the 50th and 75th Percentile for fiscal year 2009 (Most recent year available from Kaiser Health Facts)

1 point = States with Medicaid payments per enrollee between the 25th and 50th Percentile for fiscal year 2009 (Most recent year available from Kaiser Health Facts)

0 points = States with Medicaid payments per enrollee in the lowest quartile for fiscal year 2008 (Most recent year available from Kaiser Health Facts)

Source: http://www.statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4

State Percentage of eligible children in SCHIP

3 points = States with 90.0% participation or higher in SCHIP
2 points = States with SCHIP participation between 87.4 and 89.9%
1 point = States with SCHIP participation between 84.9 and 87.3%
0 points = States with SCHIP participation at or below 84.8%, the national average as of 2009

Source:http://www.insurekidsnow.gov/professionals/reports/index.html and http://statehealthfacts.org/comparemaptable.jsp?ind=868&cat=4

Party Control

Party control is an additive scale where states received points based on the party in power in a state's executive and legislative branches. Three points is given for a Democratic governor, three points is given for a Democratic legislature, and one point for a split between the two branches. There were no points given for a Republican governor or legislature.
http://www.ncsl.org/legislatures-elections/elections/statevote-charts.aspx
http://www.ncsl.org/legislatures-elections/elections/statevote-election-night-governor-map.aspx

State Affluence

State affluence is a measure of state per capita personal income which uses the 2010 Census for population data and the Bureau of Economic Affairs for quarterly state personal income. All states were calculated by dividing the average quarterly personal income in 2010 by the total population in the state for 2010.
http://www.bea.gov/iTable/iTable.cfm?reqid=70&step=1&isuri=1&acrdn=4#reqid=70&step=1&isuri=1