Examining Governors' Decisions to Oppose the "Obamacare" Medicaid Expansion

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Abstract

This paper explains governors' decisions to accept or decline Medicaid expansions offered under the 2010 Patient Protection and Affordable Care Act (PPACA). We theorize that governors' decisions to oppose the funding should depend on their party affiliation, whether the governor and the legislature are of the same party, public opinion, and the need for insurance in the state. We find the party and public opinion have very large effects on governor's decisions, while the effects of the state legislature and need are moderate at best. The extent of need for insurance has no effect on gubernatorial decisions, and the governor's party outweighs citizens' need for health insurance in the estimates.

Introduction

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

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

Health care reform is the central accomplishment of the Obama administration and has been a source of conflict between the parties since its passage in February, 2010. The Patient Protection and Affordable Care Act (PPACA, or "Obamacare") is a complex bill that was designed to improve U.S. citizens' health care coverage. One important piece of the policy's

design was a Medicaid expansion in which the national government would assume initially all and eventually 90 percent of the cost of Medicaid for a previously non Medicaid-eligible portion of the population, the group that is most at risk for being uninsured. In June 2012, the Supreme Court ruled that portion of Obamacare to be in violation of U.S. law, but the Court also provided states a way to retain their existing Medicaid programs while rejecting the expansion (Rosenbaum and Westmoreland 2012).

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

This is an easy decision for Democratic governors, but the statements from Florida Governor Rick Scott and Florida Tea Party activist Henry Kelley illustrate the difficulty that Republican governors face. Scott entered Florida politics in 2009 by establishing an anti-health reform political action committee. He opposed reform throughout his closely fought successful gubernatorial campaign in 2010, in which received substantial Tea Party support. To the dismay of key Tea Party supporters, though, Governor Scott dropped this key policy position by 2013, noting that the Supreme Court upheld the law and that to turn away federal money is negligent. Other governors face similar decisions. This paper seeks to explain why some governors have decided to oppose the PPACA Medicaid expansions and other governors have not.

The Politics of Medicaid Expansion under Obamacare

The PPACA was passed under a unified Democratic administration with no Republican

1" Kaiser Family Foundation (2012) provides a succinct discussion of the 2012 Court decision.

support, a circumstance that has fueled conflict between the parties. Republican criticism of the law contributed to their winning the U.S. House in 2010 (Balz and Branigan 2010; Brady, et al. 2011; Campbell 2010). Complaints and warnings about Obamacare also figured prominently in the GOP platform in 2012 (Thompson 2012), and the number of U.S. House votes for its repeal, defunding, or prohibition topped 40 in September 2013. The attorneys general of 26 states mounted legal challenges to the law, which culminated in *National Federation of Independent Business v. Sebelius* (132 S. Ct. 603, 2011) being argued before the U.S. Supreme Court. Some states refused to establish health exchanges, which are the marketplaces through which citizens are to shop for and purchase their mandated health insurance (Rigby 2012). The federally established "health navigators" who are intended to help provide information about state insurance exchanges are a point of contention in some states. Insurance lobbyists in several states have convinced legislators to pass laws that limit navigators' abilities to perform outreach (Kuznetz 2013). In short, national and state-level groups have spent enormous time and efforts in defeating or blocking Obamacare.

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

As of September 19, 2013, the governors of 29 states support the expansion (though fewer have seen it passed into law by their legislatures), 16 oppose it, and five are still considering it. All Democratic governors support the expansion, but not all Republican governors oppose the proposal. At present, ten Republicans support the expansion, five are still

deciding, and 16 Republicans oppose it.

[FIGURE 1 ABOUT HERE]

States' Preferences for Federal Money Differ

State governments depend on the national government for funds but vary in their tastes for federal spending. States received about 32 percent of their total revenue from national sources in 2005 (Donovan, et al. 2009). In 2012, Mississippi ranked first on the list of states relying on the national government for revenues, with nearly half of its funding (49.01%) coming from Washington. Mississippi's Republican governor opposes the Medicaid expansion. Alaska was the lowest recipient of federal support, garnering only 24.01 percent (Tax Foundation 2012) and its Republican governor also rejects the Medicaid expansion. The refusal of Medicaid expansion under the PPACA does not indicate a general disavowal of federal funds going to state or a stand against the federal deficit, but appears to represent a partisan rejection of Obamacare. In the past, governors typically accepted Medicaid expansions as a form of "free" federal money, and U.S. House and Senate members claimed credit for those expansions as a benefit to the states that was a bargain due to the steep subsidy (Brown and Sparer 2003).

Both liberal-leaning and conservative-leaning states have refused federal funds at times in the past fifty years, for both practical and ideological reasons (Nicholson-Crotty 2012). Some states refused abstinence-only funding during the George W. Bush administration and some refused to compete for Race to the Top money under the Obama administration (Nicholson-Crotty 2012). In 2010, a number of conservative states refused to accept federal stimulus money that would have extended unemployment coverage. Others refused to accept previously granted funds for high-speed rail and funds for creating a health exchange (Nicholson-Crotty 2012 449-

450). Some states take cues from the federal government on health care spending, others are not as welcoming (Weissert and Scheller 2008). The division over Medicaid expansion is consistent with other recent partisan divisions, but differs in part because of Medicaid's prominence in state health coverage and its crucial role in the PPACA plan.

The 1994 Contract with America was a precursor to the recent refusal by some Republican governors to expand Medicaid. Although Medicaid was not considered in the Contract, some Republican governors pushed for an end to the Medicaid entitlement in favor of a more limited block grant program. Their success was stymied by the Clinton administration's reaction to the 1994-1995 budget shutdown, in which the administration successfully created fears among the elderly of the effects of the block grant on nursing home care and on care for special needs children. By 1996, despite early signs that the block grant initiative might succeed, the Republican push for Medicaid block grants was defeated (Thompson 2012).

The GOP governors' failure to secure a block grant for Medicaid in the mid-1990s led Republicans not to seek large Medicaid changes until fairly recently. Block grants and other proposals to cut Medicaid did not re-emerge until 2011, with the rise of the Tea Party bloc in Congress (Thompson 2012). It is reasonable to expect that this antipathy toward Medicaid expansion among Tea Party legislators may inform gubernatorial actions on program expansion as governors weigh the political costs and benefits of accepting the funds.

Despite the early refusal to accept Recovery Act funds, and despite early disavowal of PPACA and the legal challenge to the law, some governors have softened on their prior rejection of the Medicaid expansion. Republican governors who once opposed the expansion have shifted to supporting it, albeit grudgingly. Ohio Governor John Kasich said of the uninsured "What are we going to do, leave them out in the street, walk away from them when we have a chance to

help them?" (Klein 2013). His support of the Medicaid expansion was met with strong criticism from conservative groups and failed to receive support from the Ohio legislature, leading Kasich to circumvent the legislature and use a state board to bring about the expansion. Gov. Jan Brewer (R, AZ), who initially opposed the PPACA, signed the expansion into law in June, 2013 after a protracted fight with conservatives in the Arizona House and Senate, with whom she was once joined in opposition to Obamacare. Florida's Scott shifted to support the Medicaid expansions after being assured that Florida would be allowed to continue with its managed-care style Medicaid program. It was not supported in the legislature and he did not call a special session to address Medicaid.

Governors May be Wary of Medicaid Expansion

Governors are often held responsible for state economic performance and spending regardless of whether they are able to affect either (Brace 1993). Medicaid has been described as the budget PacMan that consumes them without concern for other state spending needs (Altman and Beatrice 1990; Weissert 1992). Medicaid payments consumed nearly 24 percent of state budgets in 2011-2012. They ranged from a low of 9.3 percent in Wyoming and 30.1 percent in Florida in fiscal 2012 (NASBO 2013). Medicaid is a state-federal program designed to provide the indigent or medically indigent access to mainstream medical care. The national government pays at least 50 percent of states' program costs, but can pay as high in 83 percent in states with lower median family incomes. It is not organized on a health delivery model, but is simply a payment system that relies on private providers as a source of care. Medicaid was first implemented in 1966 and has constantly been more expensive than expected. The strain between the desire to provide access through generous eligibility and service coverage and the need to control Medicaid are longstanding problems faced by states and Medicaid program

administrators (Holahan and Cohen 1986).

The PPACA Medicaid expansion promises 100 percent of state Medicaid costs for people with incomes as high as 138 percent of the federal poverty level through 2017, after which reimbursements decline slowly and are fixed at 90 percent beginning in 2020. It is a generous offer from the national government and would do much to reduce the portions of state population who have no health insurance that is most difficult to reach, the working poor. Fiscally strapped state governments recognize that the money is not free in the long run since states will have to pay ten percent of the bill for persons who are at or below 138 percent of the federal poverty level in 2020. Some partisan critics warn that the federal government may simply remove support for Medicaid with a change of party control of Congress, leaving the states responsible for the program's entire price (Coburn and Jindal 2013; Singer 2013).

The national government has not reneged on Medicaid spending commitments in the past, although the amounts states receive through the Federal Medical Assistance Percentages (FMAPs) have changed as states' wealth has changed.[2] Income increases in the South and Southwest have resulted in those states receiving lower FMAPs and higher state Medicaid shares. Income declines relative to national income per capita in parts of the East and the Midwest have produced increases in FMAPs (and lower state Medicaid shares) in those areas (Miller 2011). Thus there is some evidence of change in FMAP among the states, but no evidence of the US government refusing to pay for Medicaid benefits.

Another state concern with the expansion is the fear that public knowledge will produce a Medicaid enrollment explosion. There is concern that states will experience a "woodwork" or "Medicaid surge" effect upon implementation of PPACA in which new Medicaid enrollees and

2The FMAP is calculated: $FMAP = 1 - .45 \times [(\text{State PCI})^2 / (\text{U.S. PCI})^2]$. A state with average income receives an FMAP of 55%, and no state may receive less than 50% FMAP, where the national government matches state spending dollar for dollar, and no state may receive more than 83% FMAP (Miller, 2011).

latent enrollees--those who were previously eligible but did not enroll--who come to the program in response to new knowledge about their eligibility and produce more-costly-to-the-states payment increases (Lewin Group 2013). Existing research shows increased knowledge of Medicaid eligibility to increase program enrollment and service use (Stuber and Bradley 2005). Thus there may be some reason to believe that Obamacare, with its health navigators and other outreach efforts to increase public knowledge, may produce higher Medicaid enrollments and spending for states.

Why Might Governors Refuse the Obamacare Medicaid Expansion?

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

Politics

Political beliefs and ideology affect Medicaid decisions, and partisan conflict has defined much of the debate over health reform (see, e.g., Grogan and Rigby 2009). Governors often oppose an opposite-party president's position, but opposition is tempered by concern for the state budget. For example, several Republican governors willingly accepted Obama administration Recovery Act funds in 2009 (Pear and Goodman 2009), and governors typically accepted Medicaid expansions mandated by the national government regardless of party (Brown and Sharer 2003). However, in the case of the Medicaid expansion under the PPACA, when the issue relates to key component of the Democratic president’s signature legislative achievement, we expect the probability that a Republican governor opposes the president to be large. Similarly,

Democratic governors should be substantially less likely to oppose the president on this highly salient, partisan issue. Elizabeth Rigby (2012) notes that partisan politics are the main influence on state government behavior on the choice to create state health exchanges, and the same may be true of the Medicaid expansion, even with such a large amount of aid available. This leads to the first hypothesis.

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

Second, governors are accountable to a constituency, so they pay attention to voter preferences and opinion. Indeed, if governors cannot appeal to the majority of the voters in their state, then their future political prospects seem bare. Republican governors are more likely than GOP legislators to support redistributive policy spending because it benefits that statewide constituency from which they must seek support (Barrilleaux and Berkman 2003; Lewis, et al. 2013). Therefore, if the people of a state support the president and his policy, then we expect that governors will be less likely to oppose the expansion. Thus, if Obama carried their state in 2012, we expect governors to be less likely to oppose the expansion. This is our second hypothesis.

> Public Opinion Hypothesis: Republican governors are less likely to oppose the Medicaid expansion funds if Obama carried their state in 2012 than if Romney carried their state.

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

hypothesis concerning politics.

LEGISLATIVE PARTISANSHIP HYPOTHESIS: Governors are more likely to oppose the federal Medicaid expansion if the state legislature is controlled by Republicans.

Citizen Needs

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

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

The size of the uninsured population among the states may affect states' choices to

expand Medicaid. Medicaid expansions were the sole effective tool used by states to increase health insurance coverage in the aftermath of the Clinton health reforms (Barrilleaux and Brace 2007; Bernick and Myers 2008; Kail, Quadagno and Dixon 2009), but only a handful of states with the most generous prior Medicaid policies used that approach to reducing uninsurance. Thus Medicaid expansion is a policy tool that's proved to work well in reducing the numbers of uninsured in the states.

Healthcare providers also stand to gain from the expansion, especially in states with large numbers of uninsured. Expanding health coverage reduces the uncompensated care burden for providers, so that healthcare suppliers, hospitals, clinics, participating physicians, managed care organizations, pharmacies, and other providers also stand to benefit from broader Medicaid coverage, which makes it more likely that they will get paid for the services they provide. Thus providers, especially not-for-profit and public hospitals, support Medicaid expansions.

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

NEEDS HYPOTHESIS: Governors are less likely to oppose the federal Medicaid expansion funds as the percent of uninsured in their state increases.

To review, we expect governors' decisions to be affected by some mixture of political and citizen needs considerations, and we test four hypotheses that fall within those heading. In the section below we discuss measurement and estimation.

Empirical Analysis

Our outcome of interest is public opposition to the Medicare expansion, so our outcome variable equals one if the governor opposes Medicaid expansion and zero otherwise.[3] We model

3We code governors who publicly support the expansion and governors who are still "weighing their options" as "not opposing" the expansion. We combine these two categories for two reasons. First, the two are conceptually similar. We are interested in why governors would publicly oppose such a generous offer from the federal government and particularly how politics and need affect this decision. Given our question, the decision to support

the outcome using logistic regression as a simple linear function of the explanatory variables along with several control variables. Our explanatory variables of interest are an indictor for whether the governor is a Republican, an indicator for whether Obama won the state in 2012, an indicator for whether the legislature is controlled by Republicans, and the percentage of the state's population that is uninsured. We use three other explanatory variables as controls: income per capita,[4] the percentage of the population that is African-American or Hispanic, and the percentage of the state's population that lives in a metropolitan area. We scale each explanatory variable to have mean zero and standard deviation 0.5, with the exception of binary explanatory variables, which we simply center by subtracting the mean. This allows us to place a common prior distribution on all coefficients (Gelman et al. 2008) and more directly compare the magnitude of the coefficients (Gelman 2008).

[TABLE 1 ABOUT HERE]

However, maximum likelihood estimation fails in two important ways with our data. First, and most importantly, the data are quasi-separated (Zorn 2005). Data reported in Table 1 show that being a Democratic governor predicts non-opposition perfectly. In this situation, maximum likelihood estimation fails.[5] As a solution, we follow Gelman et al.'s (2008) suggestion to build in a small amount of prior information into the estimation through the Cauchy prior

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the expansion or remain quiet on the issue are similar. Second, our data do not offer sufficient information to parse out the different effects that our explanatory variables have across these different outcomes. We maximize our statistical leverage by combining governors who publicly support expansion and those who have remained quiet into a single "does not oppose" category.

4 The income per capita measure also controls for the FMAP amount received by each state, as FMAP is driven by income.

5Quasi-separation leads to estimated coefficients and standard errors of infinity. In practice, though, the estimates and standard error will be unexpectedly large. How large the estimates will be depends on the numerical precision of the optimization routine. For example, using R's default convergence criteria for the `glm()` function, the estimated coefficient for the GOP governor indicator is 19.5 with a standard error of 2,146.4. When we increase the convergence tolerance standards as much as possible, we obtain an estimate of 33.4 with a standard error of 15,395,829.3. Of course, neither estimate is statistically significant, despite the pattern being extremely unlikely under the null hypothesis. See Zorn (2005).

distribution. The prior takes the form of a Cauchy distribution centered at zero with scale 2.5. The Cauchy distribution has very heavy tails, which does not rule out very large coefficients, but places higher prior weight on coefficients that are between -5 and 5. Because all variables are rescaled to have mean zero and standard deviation one-half, a logistic regression coefficient of five means that a two standard deviation increase in continuous measures or change from zero to one in a dichotomous measures increases the probability of an event from 0.01 to 0.99. Our prior simply suggests that effects larger than this are unlikely, but not impossible. Similarly, Zorn (2005) suggests using Firth's logit (see Firth 1993 and Bell and Miller 2013).[6]

Secondly, the sample of 50 states is too small to rely on asymptotic variance estimators. While maximum likelihood estimators are normally distributed about the true mean with the smallest possible variance for large sample sizes, these properties might not hold for small samples (Train 2009, Casella and Berger 2002).[7] Thus, instead of relying on the analytical (asymptotic) standard errors and assuming normality to conduct hypothesis tests and calculate confidence intervals, we use bootstrapped *p*-values and confidence intervals (Efron 1979).[8] We use the median of the bootstrapped samples as our point estimates and the 5th and 95th percentiles to construct a 90% confidence interval.

Estimates

Figure 2 shows the coefficient estimates. Table 2 provides the *p*-values that test each hypothesis directly. Notice first that the data strongly support the Gubernatorial Partisanship

6The approach is similar conceptually, but relies on Jeffrey's invariant prior distribution, which is not directly interpretable in the context of regression models. We prefer to rely on a more substantively interpretable prior distribution, but the results are consistent despite the approach used.

7For the details see Casella and Berger (2002), especially Theorem 10.1.6 (asymptotically distributed about the mean) and Theorem 10.1.12 (with the smallest possible variance). Train (2009, pp. 200-202) discusses the asymptotic properties of MLE estimators and discusses using bootstrapped samples to obtain variance estimators.

8Mooney and Duval (1993) and Carsey and Harden (2013, especially pp. 215-228) provide introductions to bootstrapping methods.

Hypothesis ($p < 0.01$), which posits that Republican governors should be more likely to oppose the expansion than their Democratic counterparts. The model suggests that GOP governors are much more likely to oppose the Medicaid expansion than their Democratic counterparts, especially in states won by Romney in 2012. In Romney states, our model suggests that GOP governors are unlikely to support the policy that some describe as a version of "Romneycare".

[FIGURE 2 ABOUT HERE]

[TABLE 2 ABOUT HERE]

Figure 2 shows how the inferences change across various estimation procedures for numeric explanatory variables transformed to have mean zero and standard deviation 0.5 and binary explanatory variables simply centered at their mean. The substantive effects reported in the main text rely on the models with a Cauchy prior and bootstrapped standard errors, but the results do not change if we rely on the analytical standard errors or Firth's logit estimates. Maximum likelihood clearly fails in this case. Though the maximum likelihood estimates depend on the convergence criteria, the default criteria in R suggests that the intercept is about -7.7 with a 90% confidence interval from 1,345 to 1,360. For the coefficient for GOP Governor, the default leads to a coefficient estimate of 18.3 and a 90% confidence interval from 1,334 to 1,371. The Cauchy prior and Firth's logit regularize these estimates, providing more reasonable findings.

We also have some support for our Public Opinion Hypothesis ($p = 0.08$), which suggests that governors whose constituency is supportive of Obamacare should be less likely to oppose expansion. An Obama victory has a relatively smaller effect among Democratic governors, with Democrats in Obama states being about 7 [-3, 24] percentage points less likely to oppose expansion than their counterparts in Romney states. An Obama victory has a larger impact on Republican governors. Republican governors of Obama states are about 32 [-6, 67] percentage

points less apt to oppose the expansion than their counterparts in Romney states.

We also have weak evidence for our Legislative Partisanship Hypothesis ($p = 0.1$), which suggests that governors of states with a Republican-controlled state legislature should be more likely to oppose the expansion. According to our statistical model, a Republican governor of a Romney state is about 27 [-8, 61] percentage points more likely to oppose the expansion if their legislature is controlled by Republicans than if the legislature is divided or controlled by Democrats.[9] The estimate is much smaller for Democratic governors in Obama states. In this situation, the model suggests that having a Republican-controlled legislature increases the likelihood of opposing the expansion by only about one percentage point [0, 19].

We have no evidence for our Needs Hypothesis ($p = 0.5$), which posits that the probability of opposing expansion decreases as need increases. However, it is important to avoid drawing the conclusion that a variable has "no effect" based only on a lack of statistical significance (Rainey, forthcoming). Instead, we should consider all effects contained in the 90% confidence interval plausible. In Democratic states (states in with a Democratic governor and legislature that Obama won in 2012), the model suggests that increasing the percentage uninsured from a low value (the 25th percentile, or 10.7% uninsured) to a high value (the 75th percentile, or 17% uninsured) has almost no effect, since the probability that these governors oppose the expansion is nearly zero, regardless of the magnitude of the need. The confidence interval suggests that the effect of need is probably smaller than a one percentile, or 17% uninsured) has almost no effect, since the probability that these governors oppose the expansion

9Unfortunately, we do not have sufficient data to parse out the separate effects of Republican-controlled, Democratic-controlled, and divided state legislatures. However, there are only four divided legislatures in the data (IA, KY, NH, and NY). In this situation, we draw heavily on prior literature to specify the model correctly. However, this conclusion is reasonably robust to alternative specifications, including a model that includes indicators for both GOP-controlled legislatures and divided legislatures. This specification strengthens the conclusion, but we prefer the more parsimonious, theory-driven specification.

is nearly zero, regardless of the magnitude of the need.[10] The confidence interval suggests that the effect of need is probably smaller than a one percent increase or decrease. However, this tiny effect occurs because our model suggests that governors of Democratic states almost never oppose expansion, which never happens in our data.

The story is much different in Republican states, however (states that Romney won in 2012, with Republican governors and legislatures). Regardless of the level of need, governors in Republican states are quite likely to oppose expansion. When the level of need is low, the model suggests that these governors have about a 59 [23, 90] percent chance of opposing the expansion. For states with a high level of need, this *increases* to about 62 [32, 84] percent. Bootstrapping the difference between these two suggests that increasing the percent uninsured from low to high leads to a one [-24, 34] percent *increase* in the likelihood of opposing the expansion. However, notice that the confidence interval does contain some reasonably large negative effects (consistent with the Needs Hypothesis), so we should be careful not to assume that the percent uninsured has no effect on governors' decisions. Indeed, governors might be a much as 24 percentage points less likely to oppose expansion when the need is high than when need is low.

However, we can also test the hypothesis that the each of the political variables has a larger effect than the percent uninsured. Since the change in probability of opposition depends on the values of other explanatory variables, the fairest test is to compare the logit coefficients directly.[11] Table 3 shows the *p*-values from each of these tests. While the evidence for opinion and legislatures is ambiguous (though the estimates are much larger, see above), we have strong evidence that gubernatorial partisanship has a larger effect on the decision to oppose the

10The chance of opposition from a Democratic governor with a Democratic legislature in an Obama state is about 0.5% [0.0, 1.6], even when the percent uninsured is set to its 75th percentile.

11Recall that the coefficients are comparable because we standardize all numeric explanatory variables to have mean zero and standard deviation 0.5 and simply center binary explanatory variables. This makes the magnitude of the coefficients comparable (Gelman 2008).

expansion of Medicaid than the level of need in the state.

[TABLE 3 ABOUT HERE]

Substantively, shifting from a Democrat to a Republican governor in an otherwise Republican state (a state won by Romney with GOP-controlled legislature) increases the chance of gubernatorial opposition by about 46 [19, 71] percentage points. Shifting a low-need to a high-need Republican state (a state with a Republican governor and legislature won by Romney) leads to a one [-24, 34] percent *increase* in the chance of opposition. Bootstrapping the difference suggests that a governor's partisanship has about a 51 [12, 80] percentage point larger effect on than need in Republican states. This means that the partisanship of the governor has *at least* a 12 percent larger effect than the need of a state.

Conclusion

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

A possible silver lining in the Medicaid expansion dispute is that it provides an opportunity for evaluation of the decision's effects on health access and spending. State welfare reforms in the 1990s allowed states considerable discretion in program design, which has made possible evaluations of specific program features (see, e.g., Soss, et al. 2001). The Medicaid

expansions may result in similar variation in programs under the PPACA and afford similar program analysis possibilities. Baiker, et al. (2013, 1722) report that the persons who received Medicaid coverage under the 2008 Oregon randomized Medicaid enrollment had "...increased access to and utilization of health care, substantial improvements in mental health, and reductions in financial strain" but the investigators report no marked improvement in health status among enrollees. The 2013 Medicaid expansion decisions may enable analysts to develop similar models using a nationwide panel in a natural experiment.

State governments rely on federal money for large portions of their budgets (Cho and Wright 2007) and the Medicaid expansion is certainly a large infusion of federal money. Refusal to expand the program means states are giving up billions of dollars that would flow into their health systems, boost their economies, and reduce uninsurance. On the other hand, states that refuse the money may be staking out a strong states-rights position, one that has received substantial support in the courts over the past thirty-odd years (Hanson 2008, pp. 24-36). The debate within states' about whether to expand Medicaid is ongoing and often reflects tension between politics and need. It is unclear how citizens will respond to their states' refusing benefits that leave large numbers of citizens without health insurance. But for now, in the tug-of-war between politics and need, politics seems to be winning in some states.

Table 1: Gubernatorial Position on Medicaid Expansion by Party

	Supports Expansion	Opposes Expansion
Democratic Governor	19	0
Republican Governor	15	16

Table 2: Summary of the Evidence for Each Core Hypothesis*

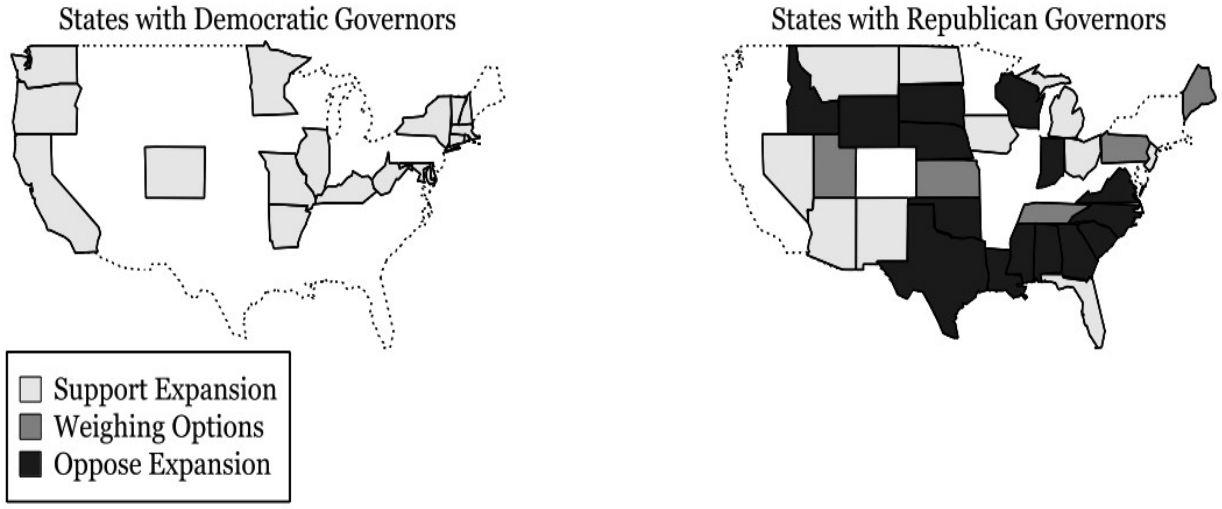
Hypothesis	p-value (one-sided)	Evidence
Gubernatorial Partisanship	< 0.01	Strong evidence in favor
Public Opinion	0.08	Weak evidence in favor
Legislative Partisanship	0.1	Weak evidence in favor
Needs	0.48	No evidence for or against

*The one-sided *p*-values are calculated by computing the proportion of 10,000 bootstrapped estimates that are inconsistent with the research hypothesis (i.e. consistent with the null hypothesis). Because our sample is quite small, we interpret *p*-values near 0.1 as offering some evidence for our hypothesis.

Table 3: Test of the Effect of Political Variables Compared to Need

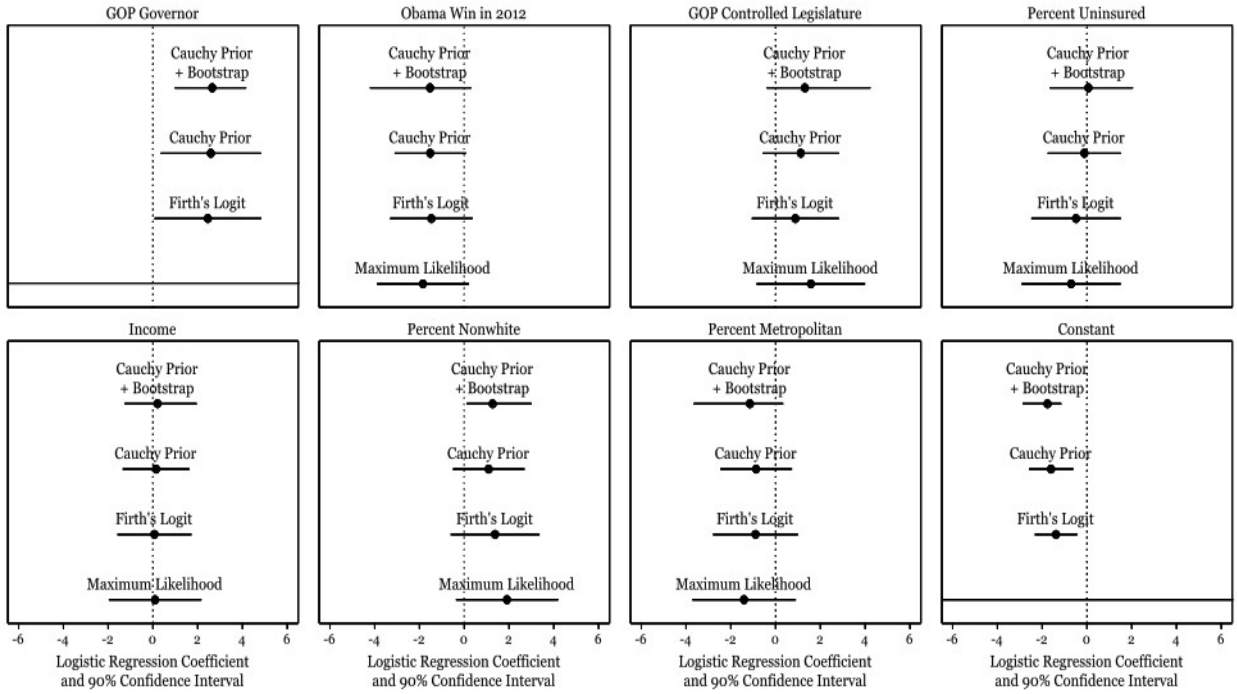
Hypotheses	p-value (one-sided)
The effect of gubernatorial partisanship is larger than the effect of need.	0.01
The effect of public opinion is larger than the effect of need.	0.11
The effect of legislative partisanship is larger than the effect of need.	0.16

Figure 1: Gubernatorial Support and Rejection of the Medicaid Expansion*



*The Democratic governor of Hawaii and the Republican governor of Alaska are not shown. They support and oppose expansion, respectively.

Figure 2: Inferences with Bootstrapped Cauchy Prior, Cauchy Prior and Firth's Logit



Technical Appendix

The Cauchy(2.5) Prior Is Not Overly Informative, But Our Model Does Not Overfit

We begin our robustness checks by showing that the Cauchy(2.5) that we rely on in the main text is not overly informative. We do this by showing the more informative priors predict out-of-sample observations better than the prior that we rely on. To do this, we computed Brier scores using leave-one-out cross validation. The procedure works as follows:

1. Start by dropping a single observation (say, Alabama).
2. Use the rest of the data (all states except Alabama) to estimate the model and the probability that the governor of the left-out state opposes the expansion. Save the estimated probability.
3. Do this for all 50 states.
4. Calculate the Brier score *B* using the equation $B=\sum_{i=1}^{n}(y_i-p_i)^2$, where y_i equals one if the governor of state *i* opposes expansion and p_i represents the out-of-sample estimated probability that y_i equals one.

We repeat the procedure above for a variety of different prior families, including the Cauchy, normal, and *t*, and vary the scale parameter across each of the distributions. Figure A1 shows how the Brier scores change as the prior family and scale vary.

Notice that the Brier scores are lower (i.e. the out-of-sample prediction is better) when the prior is more informative that the prior we rely on. However, the improvement is not dramatic, so we prefer to use too little prior information rather than too much. To err on the side of caution, we use the default Cauchy(2.5) prior suggested by Gelman et al. (2008).

Another potential concern with the small sample is that we are over-fitting the data. (The

problem of separation that we identify in the main text is just one example of over-fitting.) However, the Brier scores shown in Figure 1 should alleviate any concerns about over-fitting. Notice that the Brier score for our preferred Cauchy(2.5) is about 0.17. The lowest Brier score among the parameterizations shown is about 0.15 for the much-more-informative Normal(0.8) prior distribution. Slightly better performance from a more informative prior is expected. Indeed, Gelman et al. (2008) find a very similar pattern across their large corpus of data sets (see especially the right panel of their Figure 6). If a more informative prior fit the data substantially better, then over-fitting would be a concern. However, the pattern shown in Figure A1 suggests that over-fitting is not a concern.

With such a small sample, we make ourselves vulnerable to a situation in which a single state drives the results. To ensure this is not happening, we re-estimate the model, dropping one state at a time. We find that the inferences do not change when any single state is dropped from the analysis. Figure A2 plots the estimates and 90% confidence intervals.

Robustness to the Model Specification

While we believe the measures we use in the main text are the best measures of our concepts, there are several alternative measures that we would like to consider. In each case, we believe the alternative measure is less preferred than the measure we use in the main text, but here we expand on how these alternative measure change our results. In most cases, the alternative measure changes the *p*-value only slightly. Unfortunately, this changes the coefficient from "statistically significant" to "not statistically significant" in some cases. Using an indicator for a Democrat-controlled legislature or including both an indicator for GOP-control and a divided legislature actually strengthens our results. However, these results are not as troubling as one might initially expect. First, if these measures are indeed less reflective of our concepts, then

this increase in the *p*-values is expected. Third, all of the alternative measures have an effect in the expected direction. Finally, the alternative measures are all near statistical significance and certainly not statistically significantly different from the results reported in the main text.

Table A1 summarizes the results using the alternative measures and Table A2 shows the model estimates using the alternative measures. Table A1 compares the results when using alternative measures. Notice that although the *p*-values are not as small as we would like, all are nearly statistically significant at the 0.1 level and all the effects are in the expected direction. The state ideology measure comes from Tausanovitch and Warshaw (2013), who use public opinion surveys to estimate citizen policy preferences.

Table A2 shows the logistic regression estimates using several alternative measures for the concepts. Each explanatory variable is transformed to have mean zero and standard deviation 0.5, except for binary explanatory variables that are simply centered at their means. Notice that the measures we use in the main text (Model 1) has an AIC and BIC similar to the models using alternative measures (except for Model 2, which excludes control variables). Also notice that the model we use in the main text offers the most optimistic conclusion about the effect of the percent uninsured.

Appendix Table 1: Results using Alternate Measures.

Concept	Our Measure	Alternative Measure	Expectation	Estimate	*P*-value (one-sided)
Public Opinion	Obama wins state 2012	State Ideology (liberal to conservative)	+	+	0.05
		Obama Share in 2012	-	-	0.17
		Democrat-Controlled Legislature	-	-	0.02
State Legislature	GOP controls House and Senate	Include both Republican-Controlled Legislature and an indicator for Divided Legislature	+/+/+	+/-/+	0.06/0.61/0.14
		GOP Controls House	+	+	0.13
		GOP Controls Senate	+	+	0.12

Appendix Table 2: Collection of Logistic Regression Estimates

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7	Model 8
GOP Governor	2.58**	2.74***	2.26**	2.40**	2.64**	2.63**	2.61**	2.82***
	(1.36)	(1.37)	(1.35)	(1.36)	(1.44)	(1.41)	(1.37)	(1.35)
Obama Win in 2012	-1.52*	-1.62**			-1.85***	-1.51*	-1.66**	-1.55*
	(0.97)	(0.86)			(0.92)	(0.97)	(0.95)	(0.97)
Ideology			2.00*					
			(1.36)					
Obama Share				-1.01				
				(1.06)				
GOP Controlled Legislature	1.12	0.91	1.28	1.42*		1.05		
	(1.04)	(1.00)	(1.00)	(1.02)		(1.33)		
Democrat-Controlled Legislature					-0.82			
					(1.56)			
Divided Legislature						-0.15		
						(1.41)		
GOP House							0.93	
							(1.05)	
GOP Senate								1.03
								(1.04)
% Uninsured	-0.12	0.31	0.09	0.03	-0.11	-0.12	-0.07	-0.12
	(0.99)	(0.82)	(0.96)	(0.97)	(0.98)	(1.00)	(0.99)	(0.99)
Income	0.14		0.36	0.00	0.03	0.15	0.15	0.13
	(0.91)		(0.94)	(0.89)	(0.85)	(0.91)	(0.90)	(0.90)
% Non-White	1.09		1.23	1.21	0.93	1.11	1.08	1.09
	(0.97)		(1.00)	(0.99)	(0.94)	(0.98)	(0.97)	(0.97)
% Metro	-0.87		-0.92	-1.25*	-0.72	-0.88	-0.78	-0.85
	(0.97)		(0.99)	(0.96)	(0.93)	(0.98)	(0.95)	(0.97)
Constant	-1.60***	-1.60***	-1.73***	-1.62***	-1.61***	-1.59***	-1.59***	-1.61***
	(0.60)	(0.60)	(0.64)	(0.61)	(0.63)	(0.61)	(0.60)	(0.60)
AIC	32.48	25.91	32.35	33.43	33.00	34.47	32.64	32.51
BIC	47.78	35.47	47.65	48.72	48.30	51.68	47.94	47.80
Num. obs.	50	50	50	50	50	50	50	50

***$p < 0.05$, **$p < 0.1$, *$p < 0.2$, standard errors in parentheses.

Appendix Figure 1: Over-fitting analysis

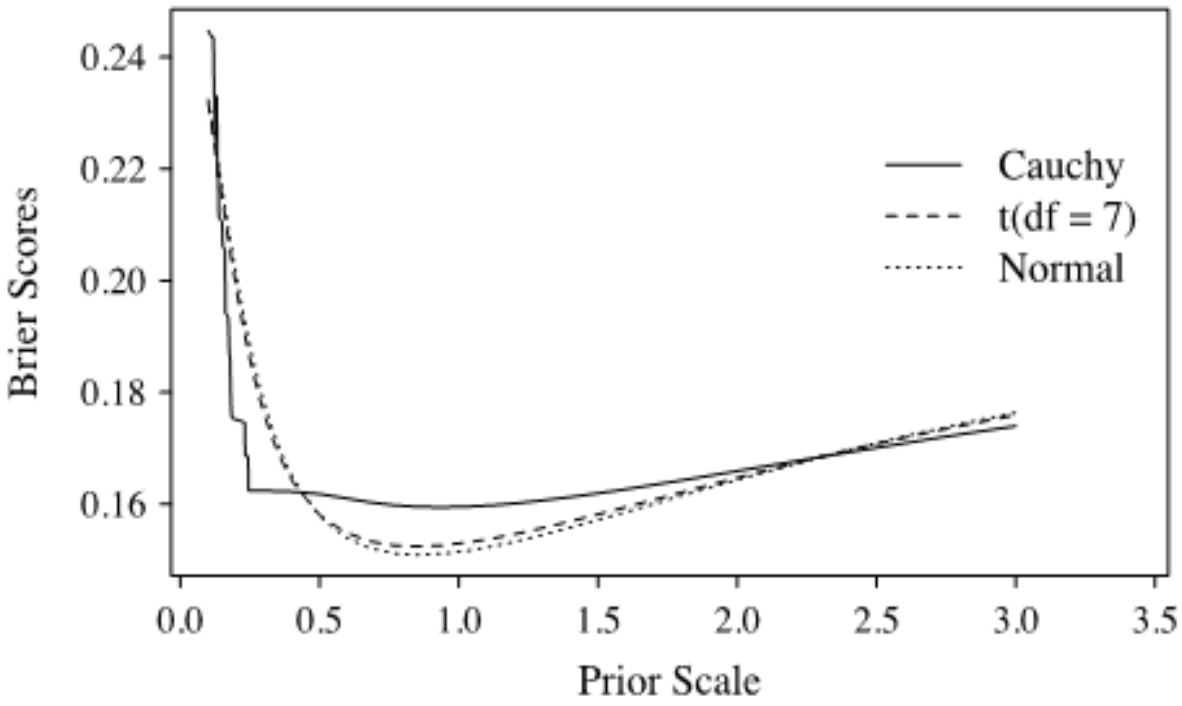


Figure A1: The out-of-sample performance of three prior distributions as the scales vary. Lower Brier scores indicate improved out-of-sample predictions. Notice that informative priors (e.g. Normal(0, 1) and Cauchy(0, .25)) only slightly outperform weaker prior distributions. Because the more and less informative priors perform similarly, we are not as worried about overfitting the data. Because we would rather supply too little prior information than too much, we choose use the less informative Cauchy(0, 2.5) prior distribution in the main analysis.

Appendix Figure 2: No Single State Drives the Results

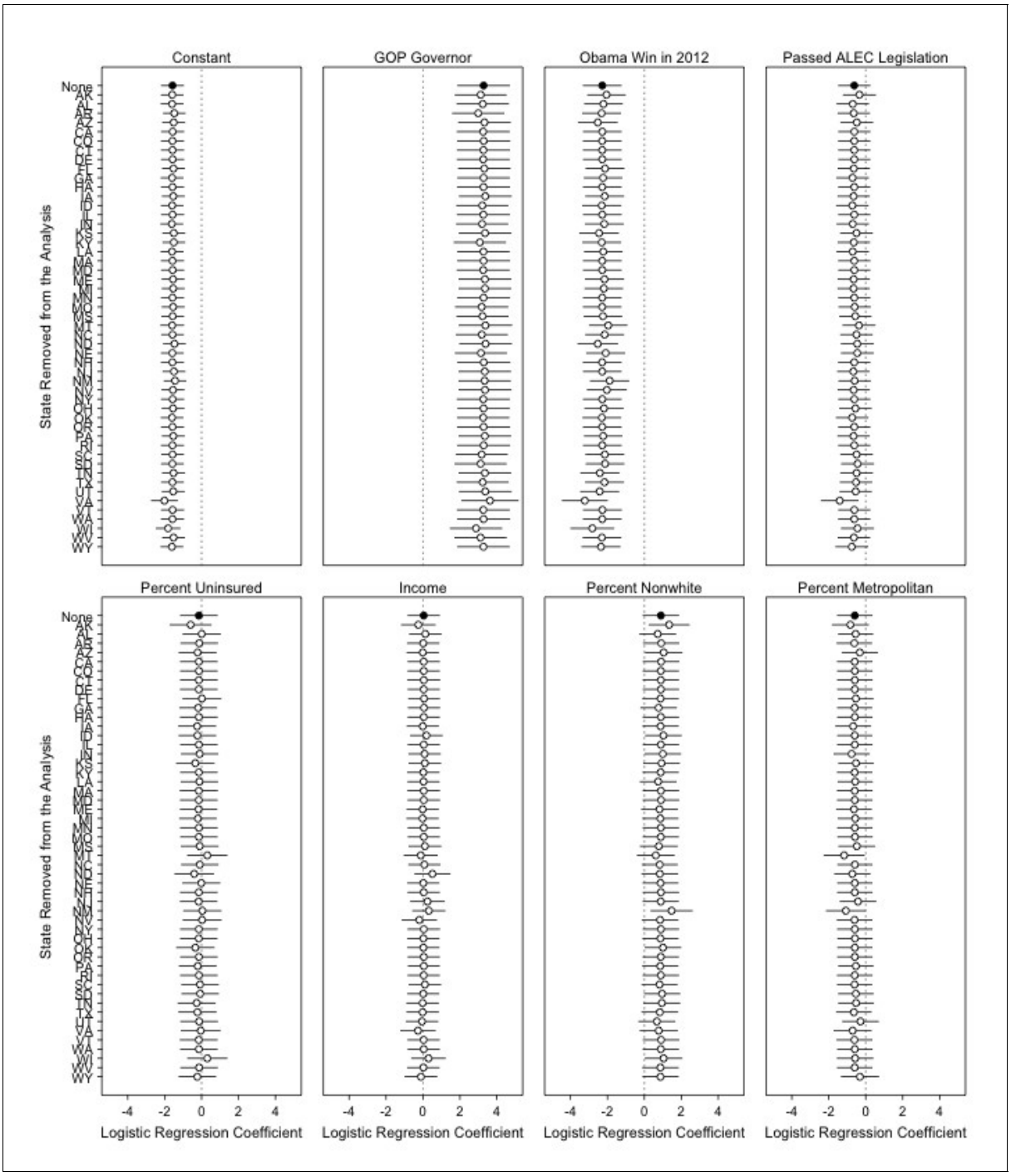


Figure A2: This figure shows how the estimates change when each state is removed from the analysis. The top estimate in each panel presents the estimate using the full data set. Notice how little the estimates change when each state is dropped.

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