

# Report on Health Reform Implementation **Business Associations, Conservative Networks, and the Ongoing Republican War over Medicaid Expansion**

**Alexander Hertel-Fernandez**  
**Theda Skocpol**  
**Daniel Lynch**  
Harvard University

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—Colleen M. Grogan

**Abstract** A major component of the Affordable Care Act involves the expansion of state Medicaid programs to cover the uninsured poor. In the wake of the 2012 Supreme Court decision upholding and modifying reform legislation, states can decide whether to expand Medicaid—and twenty states are still not proceeding as of August 2015. What explains state choices about participation in expansion, including governors' decisions to endorse expansion or not as well as final state decisions? We tackle this

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puzzle, focusing closely on outcomes and battles in predominantly Republican-led states. Like earlier scholars, we find that partisan differences between Democrats and Republicans are central, but we go beyond earlier analyses to measure added effects from two dueling factions within the Republican coalition: statewide business associations and cross-state networks of ideologically conservative organizations. Using both statistical modeling and case studies, we show that GOP-leaning or GOP-dominated states have been most likely to embrace the expansion when organized business support outweighs pressures from conservative networks. Our findings help make sense of ongoing state-level debates over a core part of health reform and shed new light on mounting policy tensions within the Republican Party.

**Keywords** health reform, Medicaid, states, federalism, interest groups

On March 23, 2010, President Barack Obama signed into law a landmark piece of American social legislation, the Patient Protection and Affordable Care Act. This ambitious policy established new regulations governing private health insurance offerings in the United States, enhanced benefits in the Medicare program, and promised major, continuing flows of federal funding to expand health insurance coverage to more than 30 million working-age citizens and family members who were previously uninsured. Coverage was to be expanded through two routes: by offering subsidies to businesses and lower-middle-income citizens to enable them to purchase private insurance on regulated marketplaces in each state and by adding millions of low-income adults to Medicaid programs run by the states (specifically, as explained in Rudowitz and Stephens 2013, by assuring coverage for adults with incomes under 138 percent of the federal poverty line).

When health reform originally passed, it looked as if the fifty state governments would play a strong role in making choices about whether to run their own marketplaces, while Medicaid expansion would occur nationwide more or less automatically. The 2010 law included powerful carrots and sticks to prod Medicaid expansions in every state. Federal funding was set to cover 100 percent of the new Medicaid costs from 2014 through 2016, then gradually drop to 90 percent of the costs in 2020 and beyond, setting the federal contribution for these new beneficiaries at a much higher level than for other groups eligible for Medicaid and the Children's Health Insurance Program. Following prior practices for federally funded programs, states were threatened with the loss of all prior Medicaid funding if they did not go along with expansion. Finally, economic incentives would also change for hospitals and health care businesses, because the Affordable Care Act included phased-in cuts to federal "disproportionate share" payments that had been made to hospitals operating

in areas with unusually high numbers of poor uninsured patients. After 2013, such people were supposed to be covered by Medicaid. In short, the Affordable Care Act as passed by Congress in 2010 offered the states resources for Medicaid expansions that, as a practical matter, they would be unable to refuse.

But the anticipated inevitability of Medicaid expansion went out the window in the middle of 2012. After health reform legislation moved from Congress to President Obama's desk with purely Democratic support, Republicans launched a protracted guerrilla war to undo the new law. This war featured repeal votes in Washington, delayed implementation in many states, and—most importantly—federal court challenges to the constitutionality of the 2010 law (Jacobs and Skocpol 2010: chap. 5). Attorneys general from twenty-six states joined the early waves of constitutional suits, which were ultimately resolved by the Supreme Court in *NFIB v. Sebelius* (132 S. Ct. 2566 (2012)) on June 28, 2012. In a bare-majority ruling, the court affirmed the constitutionality of the core of the Affordable Care Act, but at the same time fundamentally revised the law's provisions about Medicaid expansion. The justices declared that states could not be coerced to enlarge their programs. Existing funding would continue and each state could decide for itself whether or not to expand its program to include all intended beneficiaries.

In an instant, a new front in the health reform war was opened, as governors henceforth had to decide whether to propose Medicaid expansion for their states and, in most cases, state legislatures had to vote on proposals. Ideologues and partisans mobilized, and interest groups geared for battles that continue to the present day. Only a modest number of mostly Democratic states acted promptly after the Supreme Court made Medicaid expansion a choice. Indeed, in most states, early rounds of decision making stretched into 2013, the deadline to adopt the Medicaid expansion on schedule for 2014. After that, some additional states acted in 2014 and 2015 to authorize tardy expansions—bringing the total number of states expanding, or planning to do so by August 2015, to thirty plus the District of Columbia. As legislatures adjourned, twenty states still refused to accept the Medicaid expansion for 2016 and beyond.

What explains the phases and patterns of state adoptions and refusals of Medicaid expansion in the new world of federal choice created by the 2012 Supreme Court decision? That is the puzzle we tackle in this article, looking both at endorsements by governors—which tended to occur first—and at conclusive state decisions made between late 2012 and the summer of 2015. Our unique contribution is to present new statistical analyses and case study evidence about the struggles that have unfolded in

predominately Republican-led states, looking closely at the capacities and activities of business associations and networks of cross-state conservative organizations. These often clashing forces are waging a fierce civil war about whether states should accept billions of dollars in new federal funding for Medicaid expansions. Like earlier scholars, we find that divisions between Democrats and Republicans are front and center in state decisions. However, we also highlight the significance of conflicts pitting elite GOP interest groups against one another.

In Washington, DC, and the national media, fights over Obamacare look centralized and highly ideological, pitting Democrats proud of extending affordable health care to millions against conservative Republicans determined to avoid expanding the taxing and spending powers of government.<sup>1</sup> But the dynamics look different in many of the states where the key decisions about Medicaid expansion have to be made. Despite partisan polarization, Medicaid expansion has been endorsed by eighteen governors in GOP-dominated states—that is, states where two or three of the governorship, the lower legislative chamber, and the upper chamber are under GOP control. And Medicaid expansion has been officially accepted in ten such Republican states, as well as in twenty states where Democrats held two or three parts of government when the choices were made. Although all of the Democratic-dominated and Democratic-leaning states eventually accepted Medicaid expansion, Republican states have gone both ways, reflecting a divide between two of the party's organized elite-led constituencies: business organizations and right-wing ideological organizations.

Chambers of commerce are general business associations that have considerable clout in every state, and they usually applaud conservative Republican priorities such as restricting union rights or cutting regulations and taxes. However, especially when state chambers are attuned to the interests of health care businesses for which Medicaid expansion means profits gained or losses avoided, they may push governors and legislators to go ahead. Even so, right-wing conservatives can mount counterpressures. Conservative ideological elites oppose Medicaid expansion on principle and out of a well-grounded strategic conviction that any expansion of government-backed access to health insurance will, over time, advantage Democrats. What is more, these days conservative ideologues consist of a lot more than just a smattering of professors and media pundits.

1. For the role of ideology in state responses to Obamacare, see also Rigby 2012; Rigby and Haselswerdt 2013.

Ideological activists and their financial backers have built several intertwined networks of organizations operating within and across the states. The most prominent of these are the American Legislative Exchange Council (ALEC), which runs task forces for state legislators and prepares conservative and business-friendly model bills; the State Policy Network (SPN) of cooperating right-leaning think tanks and policy communications organizations; and the national headquarters and thirty-four state chapters of Americans for Prosperity (AFP), a federated advocacy group and quasi-party organization of conservative activists paralleling and intertwined with the Republican Party.

For the first time in political science research, we present systematic data on the organizational capacities and clashing roles of state chambers of commerce versus right-wing networks, data that help us analyze with some precision how these organized forces have played out in decision making about Medicaid expansions, especially in GOP-dominated or GOP-leaning states. Our analysis proceeds first by building and testing statistical models to explain key phases of expansion decisions and then by probing more deeply into the interactions of partisan and interest group forces in four Republican-dominated states: Michigan, Missouri, Virginia, and Indiana. We conclude by using our model and case study findings to briefly assess the latest Medicaid expansion fights that played out to varied conclusions in 2015.

### **Forces Shaping Medicaid Expansion Decisions**

Although state decisions over implementation of the Affordable Care Act are still unfolding, several recent academic studies offer an indication of the factors that shape lawmakers' choices to expand Medicaid or not. Lawrence R. Jacobs and Timothy Callaghan (2013) find that state variations are significantly affected by partisan control of government and also by preexisting administrative capacities and past Medicaid programs. States under full Democratic control with more generous Medicaid programs and stronger administrative capacity to deal with health insurance were found by Jacobs and Callaghan to have made greater progress in expanding Medicaid than Republican states with weaker administrative capacity and historically restricted Medicaid benefits. Echoing the Jacobs and Callaghan findings on partisanship, Charles Barrilleaux and Carlisle Rainey (2014) find greater explanatory power for variables measuring political and ideological conditions in the states, compared to variables measuring the economic stakes that states have in Medicaid expansion. Finally,

Colleen M. Grogan and Sungguen Park (2013) also affirm the impact of partisan government control and find that public opinion and racial demography may weigh in the expansion equation as well.

Existing studies underline the partisan nature of state decision making about Medicaid expansion and point to other variables worth careful consideration.<sup>2</sup> But no previous study answers the puzzle of why some conservative states where Republicans control most or all of government have expanded Medicaid or had governors propose moving forward, while others have not. As indicated in the introduction, we believe that much of the answer may lie in the mobilization and countermobilization of hefty, well-organized, and resourceful elite-led constituencies in the Republican Party orbit nationally and across the states—namely, mainstream business interests represented by their own associations in the states and more ideologically focused conservative policy networks that operate on the same national and state stages. We have therefore put extra effort into understanding and measuring the interests, goals, activities, and organizational capacities of these two sets of Republican-leaning interests, both of which have been front and center in past and present battles over Medicaid reforms and the Affordable Care Act's expansion of Medicaid.

### **Business Support**

Organized business interests are, of course, well known to lean toward Republicans. And in many states both specialized business associations and the most prominent general business associations—chambers of commerce—have potential stakes in existing Medicaid programs and changes in Medicaid rules that could bring huge inflows of new federal money into state economies and business coffers. Virtually everywhere, for instance, hospitals and hospital associations have pushed for states to accept Medicaid expansion. Hospitals stand to gain new revenues from more insured patients, and, equally important, they want to avoid net revenue losses from scheduled reductions in “disproportionate share” payments for treating the uninsured. Since hospitals and associated businesses are often economic engines for their local communities, nonexpanding states that put hospital bottom lines at risk also cost their states jobs, revenues, and profits.

Basic economics thus suggests why general business associations—local and statewide chambers of commerce above all—might also push for

2. For the importance of partisanship and ideology in state Obamacare decisions, see also Rigby 2012; Rigby and Haselswerdt 2013.

Medicaid expansion. In Missouri, for instance, the state chamber came out aggressively in favor of expanding Medicaid—practically “leading the charge” in the statehouse, according to the association’s health policy lobbyist (telephone interview by Hertel-Fernandez, April 16, 2014). As that lobbyist explained to us, “I’m not huge on Keynesian economics, but that is \$2.2 billion [the estimate for federal Medicaid expansion payments to Missouri] that wouldn’t be in our economy otherwise.”

However, we do observe variation in chamber proclivities and capacities to channel the overall desire of health care businesses to see Medicaid expanded in some form in every state. Chambers of commerce have various particular business interests represented on their boards, and they also have varied patterns of staffing that can make a difference in key policy battles. We anticipate that associations with health providers on their boards of directors and dedicated health policy staffers will be in the strongest positions to advocate for expansion. In our quantitative models, we use a 0–3 scale for chamber of commerce support:

- Score “0” if no public endorsement of expansion.
- Score “1” if the state’s chamber publicly endorses Medicaid expansion.
- Score “2” if an endorsing state chamber has either a person from a health care company sitting on its board OR has hired a dedicated health policy staffer.
- Score “3” if an endorsing state chamber has both a health provider on its board and a health policy staffer.

In our qualitative case studies, we are able to probe more deeply into the orientations and activities of hospitals, insurers, health provider groups, and small business associations. We also take note of specific features of Medicaid reform and expansion plans that make them especially attractive, or not so attractive, to profit-seeking health businesses in each state.

### Opposition from Organized Right Networks

At same time that business associations in Missouri and other states were calling for Medicaid expansion, organizations representing conservative ideological interests were doing all they could to block it. The situation in Missouri is illustrative. Opposition came from the Show-Me Institute, part of the SPN’s national network of associated conservative think tanks, as well as from the state’s AFP chapter. In addition, many Missouri legislators—including GOP House and Senate leaders—are members of

ALEC. Across the US states, each of these key conservative organizational networks is dedicated to resisting all aspects of Obamacare.

The SPN not only supports policy shops like the Show-Me Institute that issue studies and lobby within each state; it also encourages specialized, well-resourced think tanks to intervene in support of local conservative efforts in many states. The right-wing struggle against Medicaid expansion has thus been buoyed both by homegrown conservative think tanks and by nationally deployed reinforcements—such as the September 2013 presentation made to a Missouri state Senate committee by Christie Herrera from the Foundation for Government Accountability (FGA), an SPN think tank based in Naples, Florida, that was founded in 2011 with a special focus on health and welfare policy (FGA 2015; Center for Media and Democracy 2013). In state struggles over Medicaid expansion, Herrera and her subordinates have made presentations or offered commentaries all over the United States, and the FGA has paid for and disseminated polls in which citizens of states debating the issue are asked a series of leading questions, such as how they would feel about expanding Medicaid if they knew that many beneficiaries would be former felons or that the new benefits would be paid for by cuts to Medicare or education programs. The FGA's advocacy polls (or "push polls" as they are sometimes called) generate results that can be touted in right-wing media outlets and disseminated to state legislators considering how to vote at critical moments.

Operating through task forces, ALEC brings together state legislators, business leaders, and conservative policy advocates to draft and enact right-leaning, business-friendly bills in the states (Hertel-Fernandez 2014). For many years, ALEC's Health and Human Services Task Force has pushed promarket measures such as tax-advantaged health savings accounts as an alternative to health insurance. The task force also took a strong stand against the Affordable Care Act, opposing both its original passage and any state actions to cooperate with its implementation. States were urged by ALEC to pass laws or constitutional referenda embodying the tenets of a Health Care Free Choice model provision meant to undercut Affordable Care Act implementation, and in 2011 ALEC published *The State Legislators Guide to Repealing Obamacare* (Herrera 2011), detailing many recommended steps legislators could take to undermine the federal health reform law.

For its part, the AFP is a well-funded federated organization boasting thirty-four state chapters, including AFP–Missouri. The AFP's staff members mobilize conservative activists to pressure elected officials, host public forums, and conduct ad blitzes not just during elections but also during



nonelection years to call out Republican officials who support policies such as Medicaid expansion. Across the country, the AFP invested over \$30 million in 2014 alone to run ads against the Affordable Care Act (Kessler 2014).

The SPN think tanks, AFP chapters, and ALEC legislators work in tandem against state-level Medicaid expansions. But their capacities vary from state to state. To get at such variation, our statistical models use a composite measure of the combined organizational capacities of these networks, labeled “right-wing network strength.” That measure—which registers strongest for Virginia and weakest for Vermont—includes the following standardized components:

- The strength of ALEC in the state, based on the share of a state’s legislators who are members of ALEC (based on numbers in ALEC 2013b), divided into quintiles, and the number of a state’s top four legislative leaders who have ties to ALEC, including membership or regular attendance at ALEC meetings and events (based on reporting from the Center for Media and Democracy 2014). We assign one point for the quintile of state ALEC membership in which a state falls (thus a state in the fifth quintile would register with five points) and add one point for each top leader with ties to ALEC. Our measure of ALEC strength thus ranges from 1 to 9. California is an example of a state with the lowest score, while Arizona is the state with the highest score.
- The most recent budgets of state conservative think tanks participating in the SPN, calculated using Internal Revenue Service filing data, as a proportion of the budgets of left-center state think tanks that are part of the State Priorities Partnership headed by the Center for Budget and Policy Priorities in Washington, DC, and the Economic Analysis Research Network (EARN) headed by the Economic Policy Institute in DC. Although budgets are ultimately an imperfect measure of organizational resources, this variable does capture the relative balance of capacity for conservative and liberal policy think tanks operating in each state.
- As we have suggested, SPN activities are not limited to the conservative think tanks within each state—and in Medicaid expansion debates, the FGA has been especially active across many states. We therefore supplement our measures of right-wing think tank capacities within states with a variable to capture the FGA’s own trans-state lobbying efforts. States can be scored one point if there was a

presentation by an FGA staffer opposing Medicaid expansion during the legislative debate, and states can be assigned another point if the FGA conducted an advocacy poll within that state aimed at highlighting potential public opposition to Medicaid expansion. Finally, states could get half a point if FGA staff contributed commentary on specific state Medicaid proposals, including media interviews, reports, or op-eds in the *Wall Street Journal* or *Forbes* that local conservatives deployed during the debate. The scores for the states ended up ranging from 0 to 2.

- Lastly, we capture the strength of the AFP in each state with an index ranging from 0 to 4. States coded as 0 have had no AFP chapter through 2015; states coded as 1 had an AFP chapter in the past but not one surviving through the period of the Medicaid expansion debate; states coded as 2 had a chapter founded between 2012 and 2015 and were operating during the period of our study; states coded as 3 were founded between 2008 and 2011 and were continuously operating during the period of our study; and, lastly, states coded as 4 were founded by 2007 and were continuously operating during the period of our study. Codings are based on extensive review of chapter lists in AFP websites from 2004 to the present, as well as on information in AFP 2015.

In contrast to what we were able to do in our chamber of commerce index, we are unable to quantitatively measure the degree to which conservative state affiliates prioritized the Medicaid expansion debate over other issues. However, we do know that conservative affiliates were strongly opposed to Medicaid expansion everywhere. And in our case studies, we more fully probe the priorities and activities of conservative affiliates that proved critical in particular state Medicaid expansion battles and note instances where reinforcements arrived from other states or national conservative organizations.

### Additional Variables

Beyond our innovative variables measuring the balance of power between business and conservative associations, we include a series of other indicators to test or control for alternative factors propelling or impeding Medicaid expansion in the states.

Partnership is measured from 0 to 3, referring to the share of institutional veto points—governorship, state House majority, state Senate

majority—held by Democrats (we use data from the National Conference of State Legislatures). The more levers Democrats control, the more likely the state will be to proceed with Medicaid expansion. (Notably, we also tested alternative measures of partisan balance, including the share of legislative seats held by Democrats, and produced essentially identical results.) We coded Nebraska as fully Republican controlled, even though it has a unicameral legislature. Results do not change if Nebraska is omitted. In models examining multiple years together, we operationalize state partisanship with a measure of the cumulative Democratic control of government, ranging from 0 (no control in any of the years) to 9 (full control of both houses of the legislature and the governorship in the three years we study).

Various scholars have pointed to public support for Obama, support for health reform, and general state liberalism as factors spurring expansion. We tapped into this factor by measuring Obama's vote share, either in 2008 or in 2012 (we use data from the US Election Atlas). We expected that liberal-leaning states whose voters were more favorable to Obama would be more likely to expand their Medicaid programs. We use the 2008 vote share for the analysis through 2012 and the 2012 vote share thereafter. Again we tried alternative measures, such as estimated public support for the Affordable Care Act and for Medicaid expansion and found similar results; we used data from Barrilleaux and Rainey (2014). We prefer to use Obama's vote because this variable is a better indicator of the overall liberalism of a state's citizens—a factor more likely to weigh in the thinking of governors and legislators than results from scattered public opinion polls.

Finally, to get at policy environments in the states, we included a measure of the average income eligibility limits imposed on Medicaid recipients for adults and children, called Medicaid generosity (we used data from the Kaiser Family Foundation). Following work on policy feedback effects (Skocpol 1992; Pierson 1993), as well as the recent study by Jacobs and Callaghan (2013), we anticipated that states with more generous income limits in their Medicaid programs would be more likely to embrace the expansion. That could be true for one or both of two reasons: because the state is committed to relatively generous Medicaid benefits and because the state will find the very high federal subsidies for beneficiaries just above the poverty line very attractive.

To be sure, there are a number of other variables that we could potentially include in our analysis that represent alternative explanations for Medicaid state decisions. But given our very small sample size (as few as thirty-three

states in some models), we are reluctant to add many more variables and instead focus on testing our own key hypotheses about the specifically *political* factors influencing state expansion decisions. We note, however, that our results are robust to controlling for two other factors that often shape state policy decisions: an indicator for Southern states and the size of African American populations in the various states.

### **Modeling State Outcomes in Key Periods**

Using the variables we have defined, we explore the factors shaping two kinds of state-level decisions about Medicaid expansion: decisions by governors about whether to endorse Medicaid expansion for their states and actual state determinations about whether to proceed with the expansion. Governors are pivotal state officials and have long played a central role in Medicaid policy making (Thompson 2012). In the current consideration of Medicaid expansion to implement a major prong of the Affordable Care Act, governors have tended to formulate positions and proposals ahead of responses by state legislatures and have sometimes expanded the program without legislative approval. By mid-2015, gubernatorial endorsements had occurred in thirty-eight states, even though only thirty of those states had officially accepted expansion.

Importantly, as we set up our analyses, we did *not* expect that the forces shaping the gubernatorial and state decisions would necessarily be the same at different phases of the overall Medicaid expansion struggles that have played out across the fifty states. The politics of Medicaid expansion after the enactment of the affordable care legislation unfolded in three distinct contexts and phases:

- An initial, anticipatory phase of Medicaid expansion politics got under way with the signing of the Affordable Care Act in March 2010 and lasted until the constitutional challenges were resolved in late June 2012. During this period, many officials in GOP states were challenging the very existence of the health reform law and the Supreme Court had not yet made Medicaid expansion optional. There is little need to look into state-level variations in this period.
- After the Supreme Court's June 2012 ruling that states could opt out of the Medicaid expansion, state-level politics became highly pertinent. Nevertheless, because the official start of expanded Medicaid funding was not until January 1, 2014, and another presidential election was about to happen in November 2012, reluctant states

**Table 1** Phases of State Choices about Medicaid Expansion

	Late June–December 2012	January 2013–July 2015
Governors supporting expansion	CA, CT, DE, HI, IL, MD, MA, MN, NY, OR, RI, WA, VT, AR, MO, ND, NV (17)	CO, NM, AZ, MT, OH, MI, NH, FL, PA, NJ, WV, KY, IA, VA, UT, IN, NC, WY, AL, TN, AK (21)
States expanding Medicaid	CT, HI, NY, VT, NV (5)	NM, MN, ND, AR, WV, MD, CO, AZ, CA, NJ, WA, DE, RI, MA, IL, KY, MI, OR, IA, OH, NH, PA, IN, MT, AK (25)

could hang back. Quite a few governors did endorse expansion in this period, and a few states formally acted during the compressed period between late June and December 2012. But the early fault lines were almost entirely partisan, with endorsements and enactments happening mostly in liberal states where Democrats held power.

Especially in states where Democrats held little sway, the critical period commenced in 2013. States that wanted to start collecting federal money for Medicaid expansion in January 2014 had to decide by 2013. Of course, even after that first deadline was missed, states could still claim additional Medicaid funds to start in 2015 or 2016. As deadlines loomed, business associations realized that they could lose profits and revenues if their states did not act. Meanwhile, after Obama was reelected, right-wing interests understood that they had to block the progress of Medicaid expansions state by state. Thus, from our perspective, the most interesting and consequential phase of decision making for dozens of states stretched from 2013 into 2015. In this phase, we expect clashing organized interests to have an impact above and beyond partisan balances.

Our statistical analysis of varying state outcomes thus separates regressions for two periods: first, the 2012 juncture following the Supreme Court decision and, second, the period from 2013 into 2015 (for a summary, see table 1). In each period, we look first at gubernatorial endorsements and then at overall state decisions about Medicaid expansion. Given that our outcomes to be explained are binary, we estimate logistic regressions, although we arrive at similar results with ordinary least squares estimations. The 2013–15 models exclude the states where governors endorsed or states made determinations in 2012.

## Results from Regression Models

Our discussion of the statistical results begins by considering when and why governors, the key state executives, have come out in favor of Medicaid expansion as a good step for their states to take. Table 2 presents results for models looking at the late 2012 period and for the longer 2013–15 phase.

As model 1 reveals, in the late 2012 juncture, only the overall partisan balance of state government significantly predicts public decisions to endorse Medicaid expansion by governors of either party. That is, the critical factor was whether Democrats or Republicans controlled two to three of the major institutional venues: the governorship, the state House, and the state Senate. Shifting from full Republican to full Democratic control of the key institutional venues increases the probability of a gubernatorial endorsement of Medicaid expansion in 2012 by a whopping 69 percentage points ( $p < .01$ ; this and all subsequent predictions represent average marginal effects).

In model 2, we see that overall partisan balance in state governments continued to influence gubernatorial endorsements in the 2013–15 phase. But we also see a significant impact from state chamber of commerce support for expansion, especially if chamber leadership and staff provide greater capacity for lobbying state lawmakers. Governors of states in which the chamber fully supports Medicaid expansion are 54 percentage points more likely to endorse expansion ( $p < .01$ ). Thus the chamber's impact, as measured on our scale, is roughly equivalent to the effect of institutional partisanship in state governments, because in the 2013–15 phase, a shift from full Republican to full Democratic control increases the odds of gubernatorial support by 47 percentage points ( $p < .01$ ). Notably, however, we do *not* find that stronger right-wing networks have significant effects on gubernatorial endorsements. As we will see, the strength of those networks matters more for ultimate state decisions than for governors' endorsements. Governors, it seems, are chiefly responsive to partisan balances and business preferences as channeled by statewide chambers of commerce.

Moving on to consider the bottom line—state decisions about Medicaid expansion—we present full logistic regression results in the second two columns of table 2, again with models referring to the 2012 juncture versus the 2013–15 phase. Model 3 in table 2 addresses state expansion choices in 2012. As anticipated, the only statistically significant predictor of expansion immediately following the Supreme Court decision was partisan control of state government. Moving from full Republican to full

**Table 2** Predicting State Decisions about Medicaid Expansion

	Model 1	Model 2	Model 3	Model 4
	Gubernatorial Support 2012	Gubernatorial Support 2013–15	Expansion 2012	Expansion 2013–15
Democratic control	1.61*** (0.58)	0.60* (0.33)	1.39* (0.86)	0.50* (0.27)
Right-wing network strength	-0.05 (0.32)	-0.00 (0.21)	-0.61 (0.51)	-0.53** (0.27)
Chamber of commerce support	0.60 (0.49)	1.19*** (0.46)	-0.13 (0.52)	1.14** (0.57)
Obama's vote share	0.11 (0.09)	0.00 (0.07)	0.03 (0.09)	0.07 (0.09)
Medicaid generosity	0.40 (0.94)	-0.47 (1.19)	-0.86 (1.33)	-0.19 (1.38)
$R^2$	0.55	0.34	0.45	0.55
% correctly predicted	86	79	90	86
$N$	50	33	50	43

Note: Logistic regression results

\* $p < .10$ ; \*\* $p < .05$ ; \*\*\* $p < .01$

Democratic control of the three branches in 2012 increases the probability of states deciding to expand Medicaid late that year by 26 percentage points ( $p = .06$ ).

When we shift to exploring determinants of state decisions in the later 2013–15 period in model 4, the picture becomes somewhat more complex—and considerably more interesting. Now partisanship, right-wing network strength, and support from the state chambers of commerce all emerge as statistically significant predictors of state decisions to expand Medicaid. Moving from full Republican to full Democratic control of state governments during the 2013–15 period increases the probability of expansion by 52 percentage points ( $p = .02$ ). Moving from no endorsement of expansion by the state chamber to situations where the chamber not only endorsed expansion but had dedicated staff focused on health policy and health care businesses represented in chamber leadership increases the probability of Medicaid expansion by 37 percentage points ( $p = .01$ ). The chamber effect measured on our scale is, in short, nearly three-quarters the size of the government partisan-control effect. Both organized business support and partisan control of state government have large and significant impacts on the fate of Medicaid expansion.

What about opposition from right-wing groups? Unlike the situation for the models about gubernatorial endorsements, greater right-wing strength greatly reduces the probability of a state decision to expand Medicaid. In our model, moving from a state with the weakest to the strongest right-wing forces reduces the probability of expansion by a full 70 percentage points ( $p = .01$ ), or about the same effect size as partisanship. A less extreme shift in right-wing network strength from its 25th to 75th percentile (or from North Dakota to Arkansas) is predicted to decrease the probability of Medicaid expansion by 21 percentage points ( $p = .07$ ). Conservative mobilization, then, clearly matters for expansion debates. In further analyses we also conducted but do not detail here, we learned that FGA interventions and the relative strength of SPN-affiliated think tanks account for most of the explanatory power in our overall index of right-wing network strength. However, all components in our index are correlated and, as our later case studies will show, the various intertwined right-wing networks complement and reinforce one another.

In sum, our statistical analyses using new organizational measures reveal consequential impacts—independent of overall partisan control of government—from business and ideological groups engaged in conflicts over state decisions about Medicaid expansion as part of national health reform. Where the most prominent general business associations, state chambers of commerce, have strongly pushed for expansion, governors from both parties have been more likely to embrace this course and, to a lesser extent, the states involved have been more willing to authorize expansion. Strong right-wing networks can, however, temper or eliminate the pro-expansion influence of business associations for expansion decisions.

### **A Closer Look at Michigan, Missouri, Virginia, and Indiana**

Statistical modeling clarifies the general picture of the political forces shaping US state decisions about Medicaid expansion under the Affordable Care Act. But such modeling goes only so far, leaving more to be learned from explorations of the specific ways in which key political and organizational processes have played out in particular states. We cannot tell fifty state stories, but we explore in depth four states largely controlled by Republicans where conflicts between business and ideological conservatives have contributed to different outcomes. In the conclusion to our article, we look very briefly at the five states that have been sites of the most recent intra-GOP expansion wars.



Comparing Michigan, Missouri, Virginia, and Indiana is revealing precisely because major explanatory factors aligned similarly but conservative countermobilization varied. In crucial ways, the stage was set for all of these states to approve expansion, because governors proposed to move ahead and expansion garnered strong support from statewide chambers of commerce. But of course Republican predominance meant that there were bound to be arguments. If we consider only degrees of partisan sway, then the divided GOP-leaning governments in Missouri and Virginia (where Democratic governors contended with Republican legislatures) would seem to have been more conducive to expansion than the totally GOP-controlled governments in Michigan and Indiana. Yet the latter two states were the ones that chose to expand Medicaid, whereas legislatures have stymied efforts in Missouri and Virginia. Here is where our focus on contention between business and ideological conservatives offers insight. Looking closely at the unfolding political processes in these states, we see stronger pushes from mainstream business in Michigan and Indiana versus disproportionate counterpressures from conservative organizations in Missouri and Virginia—particularly conservative pressures of the sort that can influence Republican state legislators.

### Business-Oriented Republicans Triumph in Michigan

Michigan is almost a textbook case of business-oriented Republicans forging an alliance with minority Democratic caucuses in the legislature to push through a form of Medicaid expansion especially attractive to for-profit interests (Jones 2013; Cohn 2013). On our overall statistical measures, Michigan registers a strong probability of moving forward, because right-wing networks of average strength went head-to-head with a state chamber of commerce fully equipped to deliver on its endorsement of Medicaid expansion. State chamber endorsements are strong predictors of both governors' endorsements and expansions. Yet a closer look at the Michigan process underlines the additional importance of support from health providers and business associations outside of liberal-leaning metropolitan areas and reveals that Michigan became an early GOP state adopter in significant part because a firmly business-oriented governor mobilized an encompassing alliance for a specific bill he could promote as a profit-oriented form of "Medicaid reform."<sup>3</sup>

3. For a cynical conservative perspective on this maneuver, see Hart 2013.

Riding the Republican electoral wave in 2010, Rick Snyder, a former computer company executive and venture capitalist, was elected governor of Michigan with 58 percent of the vote, succeeding outgoing Democratic governor Jennifer Granholm. At the same time, Republicans took overwhelming control of both legislative chambers. In 2014 Snyder narrowly won again, and Michigan Republicans retained their legislative majorities. Both the governor and his GOP legislature have relentlessly pursued conservative fiscal and social priorities. Perhaps most prominently, Michigan GOP lawmakers pushed “right to work” legislation aimed at countering the state’s labor unions, which was narrowly passed in a rushed December 2012 vote with no hearings, overcoming fierce opposition from Michigan Democrats and the state’s once powerful labor movement.

Conservative as he is, Snyder has always made it clear that catering to state business interests is his first priority (see, e.g., Cwiek 2013). In an early signal that he would accommodate health reform implementation despite not approving the 2010 law, Snyder was the lone GOP governor to refuse to sign a June 2011 letter from the Republican Governors Association asking Congress to repeal the health law (Jones 2013). In February 2013, Snyder included in his budget a proposal he touted as Medicaid expansion and reform through a Healthy Michigan plan that would expand prior state practices of contracting with private health plans and (if federal authorities approved the necessary waiver) require cost-sharing contributions from the close to half a million projected new beneficiaries (Ayanian 2013; Fangmeier, Jones, and Udow-Phillips 2014). Learning from his previous failure to persuade Michigan’s Republican legislature to set up a state marketplace, Snyder channeled the Healthy Michigan proposal through the friendly Michigan Competitiveness Committee in the House and had arguments and allies lined up for a big, concerted push in 2013. Snyder could also point to a University of Michigan study in which the overwhelming majority of the state’s physicians said they were willing to take on more Medicaid patients (discussed in Kliff 2013b).

Snyder’s proposal was immediately pushed by a coalition called Expand Medicaid that included major providers along with the usual labor unions and consumer advocates. The Michigan Association of Health Plans (2013) was supportive, and the Michigan Health and Hospital Association (2013) urged CEOs to “engage [their] hospital trustees,” write op-eds (such as Breon and Spoelman 2013), distribute fact sheets, and hold community forums. Governor Snyder toured the state along with the head of the Small Business Association of Michigan, an association that helped him parry ongoing opposition from small and medium firms in the National

Federation of Independent Business (or NFIB; Anders 2013). This national association pushed against Obamacare implementation nationwide, but its state director acknowledged that “opposition to expansion was lower in Michigan’s NFIB chapter than in other states” (quoted in Anders 2013).

Most important for expansion prospects, in May 2013, a leader of the influential Michigan Chamber of Commerce testified in the legislature in support of Snyder’s Healthy Michigan proposal (*Medicaid Expansion and Reform: Testimony to the House Competitiveness Committee, 97th Leg., Reg. Sess. (Mich. 2013)* (statement of Wendy Block, Director of Health Policy and Human Resources for the Michigan Chamber of Commerce)), even as regional chambers and other business groups lobbied the legislature to act and pointed to studies documenting the favorable effects expansion would have on Michigan’s economy and employers’ bottom lines (Gautz 2013). Large employers were told that they would face extra tax penalties if Medicaid was not expanded (see Haile 2013).

Despite the full-court press from the governor and his allies, Republican legislators refused to fall in line easily, especially those in the Senate. Many legislators had constituents hostile to Obama and were thus ripe for right-wing lobbying. Urging eighty-seven adherents to pressure legislators to vote against Snyder’s proposal, AFP–Michigan (2013b, 2013a) paid for a “six-figure ad buy” and mounted community forums titled “Medicaid Expansion, Nothing but Hot Air.” The organization’s state director, Scott Hagerstrom, threatened to mount primary challenges against Snyder and legislators who voted for expansion. Other right-wing forces joined the oppositional drumbeat, including the advocacy group FreedomWorks–Michigan, assorted local Tea Parties, and the state’s well-funded, long-established conservative think tank, the Mackinac Center for Public Policy, which “released multiple studies, held a series of events, and published numerous blog posts and news items” (Hart 2013) to challenge the claim that Snyder’s Healthy Michigan represented true reform and to stress that “voting yes on Medicaid expansion is voting for Obamacare” (Jack McHugh, qtd in Spencer 2013).

Right-wing opponents came close but fell just short in the legislature. Snyder had more allies in the House, which passed his proposal 76–31 in June 2013 (with all but one Democrat in support and Republicans in favor and opposed split 28–30). But at that juncture, GOP Senate leaders appeared to kill the legislation when they would not bring it to the floor with a majority of their caucus opposed. Only after a summer of furious public campaigning on both sides, with Snyder and his business allies fully engaged, did a complex series of backroom maneuvers allow for

expansion to pass the Senate, on a second try, by a vote of 20–18 on September 3 (Gray 2013). All but one Democrat voted yes, joined by eight Senate Republicans—including a last-minute favorable switcher, Senator Tom Casperson, from Escanaba in the Upper Peninsula.

A close look at Casperson, as well as other Republicans who voted for expansion, reveals the enormous importance of lobbying pressures from regional chambers of commerce and health care businesses in the parts of Michigan far from Detroit and other big-city centers. Casperson had previously opposed Medicaid expansion but cited hard-pressed northern hospitals as the reason he switched his vote, despite his overall opposition to Obamacare (Heinlein 2013). Another crucial vote was provided by Senator Howard Walker of Traverse City in western Michigan, who was pressed publicly to vote yes in order to “preserve and grow a viable rural health care delivery system” in a lengthy open letter from the CEO of Munson HealthCare, touted as “northern Michigan’s largest health care system” (Ness 2013). The cross-pressured Walker eventually went along with obvious ambivalence, accompanying his favorable vote with yet another denunciation of Obamacare as “one of the worst pieces of legislation passed by Congress” and one that he hoped would still be repealed (quoted in Gray 2013).

Tellingly, six of eight Republican senators who provided crucial votes for Governor Snyder’s proposal were from nonurban districts and had previously voted for the “right to work” antiunion legislation strongly supported by all of Michigan’s ideological right-wing groups and a major priority of ALEC. In short, the six senators who split from the right wing on Medicaid expansion were not liberals or even moderates. Nevertheless, when push came to shove on the question of Medicaid expansion fashioned in a market-friendly form, this pivotal bloc of Michigan lawmakers followed their businessman governor in catering to organized business preferences forcefully expressed by a veritable chorus of state and regional associations.

### Battles to Legislative Checkmate in Missouri and Virginia

Across all US states, strong support from statewide chambers of commerce and other business associations is powerfully associated with gubernatorial support and eventual official action to expand Medicaid, which helps explain why our basic model suggests that Missouri and Virginia should have adopted some version of expansion. Governors have proposed expansion in both states, and broad coalitions including leading business

associations have lobbied for it. But legislation has been blocked for several years, illustrating the capacity of right-wing networks to persuade Republican-led legislatures to parry even overwhelming pressure for Medicaid expansion.

The basic Missouri story is simple. Republicans have held large—and growing—majorities in the state's general assembly, but a moderate Democrat, Jay Nixon, has been governor during the period when implementation of health reform has been at issue. After his plans to establish Missouri's own health care exchange were frustrated, Nixon signaled that his 2013 budget would propose to expand Medicaid to an estimated 250,000–300,000 more poor citizens, citing both humanitarian and fiscal reasons. Starting in 2013 and continuing through 2014 and 2015, a broad and growing array of groups in the state mobilized to push for expansion. Supporters include the Missouri Hospital Association and many health provider groups (Pfannenstiel 2013; Missouri Scout 2015) plus the Missouri Medicaid Coalition (2015) of unions, liberal advocates, and social service providers and religious groups serving the poor. Lobbying for expansion has also come from leading Missouri professional and business associations, regional chambers of commerce, and the Missouri Chamber of Commerce as well as the Associated Industries of Missouri (Missouri Scout 2015; Ferguson 2013; Pfannenstiel 2013). Starting in January 2014, the chamber deployed a very credible paid lobbyist, former Republican senator from Missouri Christopher “Kit” Bond, to attempt to persuade fellow conservatives in the state legislature to proceed with Medicaid expansion (Lieb 2014a).

At the start of Missouri's debates, the Missouri Budget Project—a liberal-leaning think tank affiliated with the nationwide State Priorities Partnership of kindred groups focused on budgets and social policies (Hertel-Fernandez 2015; Hertel-Fernandez and Skocpol 2015)—issued a comprehensive empirical account of the coverage gains and economic benefits that expansion would bring to all regions of the state, including rural communities. The report compared the estimated \$1.56 billion gains to “bringing in a major new corporation to the state” (McBride, Watson, and Blouin 2013: 3). But factual reports and widespread advocacy alike fell on deaf ears in the general assembly. Action was blocked in the House, and on February 5, 2014, the Missouri Senate defeated Governor Nixon's proposal by a 23–9 party-line vote (Ashtari 2014). After that, Republican Senator Ryan Silvey introduced a more market-oriented version of Medicaid expansion fashioned after Arkansas's approach, but leadership blocked a vote on this bill, and five key GOP senators vowed to filibuster, if

necessary, to prevent future considerations. One of them, Senator Rob Schaaf, was a family physician who was involved in a “long-standing feud with the Missouri Hospital Association” and also showed “outspoken contempt for people in need of government help” (Shelly 2014). Another opponent, Senator John Lamping, declared that expansion proponents should “find something else to do. . . . Go convince this current federal government to repeal Obamacare—you have a better chance of that happening than expanding Medicaid in Missouri” (quoted in Lieb 2014b).

Repeatedly in the 2013, 2014, and 2015 legislative sessions in Jefferson City, the state capital, not just Democrats but some Republican legislators in the House and Senate tried to get committee and floor consideration for increasingly more conservative variants that would use federal expansion grants to shift Missouri’s Medicaid program toward private insurers while imposing new rules and co-payments on beneficiaries (Young 2014). Governor Nixon signaled his openness to successively more conservative changes (see, e.g., Noles 2015), but these proposals came up against the same brick wall of opposition from key Missouri House and Senate leaders, backed by most legislators in the GOP caucuses (Fines 2015; J. Hancock 2015).

How are we to understand the adamant stance of most GOP state legislators in Missouri—their outright refusal to countenance any form of Medicaid expansion for several years? They have held firm, even as newspaper editorials chastise Republican obstructionists, as Missouri hospitals and health providers decry a tightening fiscal squeeze, and as advocates demonstrate for expansion at the state capital and hire field organizers to go door-to-door in legislative districts (Woodall 2015). Even more pertinent, why are Republicans obdurate even as the number of professional groups, business associations, and chambers of commerce endorsing Medicaid has steadily grown (Yokley 2015)? Any fair assessment of the simple balance of mobilization by organized pro- and anti-expansion forces outside of the Missouri legislature cannot help but conclude that the pro-expansion coalition is vastly weightier.

To be sure, conservatives have mobilized too. Missouri’s APF chapter ran ads against Medicaid expansion and urged activists on its e-mail list to attend community forums and contact legislators to express opposition (AFP–Missouri 2013a, 2014a). It is also one of a small number of state-level chapters that put out a detailed annual scorecard on exactly how each state senator and representative voted on the AFP’s priorities—and the 2013 and 2014 “Prosperity Report Cards” highlighted key votes blocking Medicaid expansion (AFP–Missouri 2013b, 2014b). Active in another

way, the state's conservative think tank, the Show-Me Institute, produced reports and op-eds (see, e.g., Ishmael 2014) and sent its director to testify at a key early Missouri House hearing on January 29, 2013, where he issued a strong warning that "committing to future state entitlement spending of this magnitude without accounting for the entitlement's ultimate costs is a recipe for budgetary disaster" (Ishmael 2013: 2). Similarly, the FGA sent its top health policy official, Herrera, to testify against expansion before a Senate committee (Missouri Senate Staff 2013: 13). Finally, yet another organized conservative force in the state (one not included in our cross-state index) is the billionaire-backed Missouri Club for Growth, which has directed large election contributions to right-wing Republicans who can be depended on to vote to lower taxes, undercut labor unions, and reduce public social provision (*Missouri Times* 2014). But even taking the club into account, the overall balance of forces maneuvering outside the legislature in Missouri's battles has been tilted toward proponents of Medicaid expansion.

To understand Missouri's Medicaid expansion stalemate, we need to look inside as well as outside the general assembly. Here one of the organized conservative networks in our cross-state index—ALEC—seems to have helped make legislators open to arguments from conservative think tanks and advocacy groups. Well before specific Medicaid expansion proposals came up for debate, ALEC's conferences and task forces influenced the outlooks of many Missouri legislators, including House and Senate leaders, shaping or reinforcing their views not just about health policy but also about taxes, government regulations, and social programs in general. In Missouri, debates about Medicaid expansion have been focused, almost obsessively, on the potential consequences for the state's fiscal condition, with less attention to overall economic growth or humanitarian considerations. Beyond the claim that health reform is a mortal threat to personal and enterprise freedom, the idea that Obamacare is an unaffordable entitlement, a burden on present and future taxpayers, has been central to ALEC's push against health reform (ALEC 2013a, 2013c; Herrera 2011).

Unlike the Michigan legislature, which is highly professionalized—with lengthy sessions and relatively high levels of staffing to help members understand issues—the Missouri legislature is a much more amateur and part-time operation. Research shows that state legislatures without much staff support of their own are more open to outside offerings such as the "model bills" and studies of policy issues that ALEC disseminates (Hertel-Fernandez 2014). Many Missouri legislators have participated in ALEC

meetings and task forces, including the ALEC Health and Human Services Task Force (Center for Media and Democracy 2015a). Moreover, in 2011, Missouri became one of about a dozen states to quickly pass ALEC's model Freedom of Choice in Health Care Act, intended to hinder Affordable Care Act implementation. The bill's lead sponsor, state senator Jane Cunningham, explained to the *St. Louis Post-Dispatch* that this happened after she "learned about the idea from ALEC and brought it back to Missouri" (quoted in Greenblatt 2011). Importing ALEC model bills seems to be a regular move for Missouri legislators: at one point in 2014, Governor Nixon vetoed a bill because, he said, "in copy and pasting from this ALEC model act, the general assembly failed to correct" boilerplate elements that referred to the wrong chapters in Missouri's own state code (quoted in Sandbothe 2014). Shared priorities are also reinforced at ALEC meetings. In the spring of 2013, Missouri representative Sue Allen sponsored a resolution presented for a vote by ALEC national leaders calling for all states to block Medicaid expansion (Herrera 2013b; ALEC 2013a)—even as she was doing her part to heed that advice back home in Jefferson City.

Overall, in 2013 ALEC (2013b) claimed 57 members out of the 197-person Missouri legislature, and most of these lawmakers opposed Medicaid expansion. Looking within the Missouri House, we found that GOP members with ties to ALEC (either membership or participation in events) were substantially more likely to have voiced opposition to expansion. Ninety-one percent of House GOP members who had ALEC ties opposed the expansion, compared to 71 percent of Republicans without such ties. This correlation held up even when we controlled for the ideological orientation of members' constituents (using data from Tausanovitch and Warshaw 2013).<sup>4</sup>

Indeed, as the Missouri House repeatedly killed expansion attempts, ALEC-affiliated GOP leaders in that chamber—including the Speaker of the House, the majority floor leader, the assistant majority floor leader, and the majority caucus chair—took active steps to prevent compromise measures sponsored by other Republicans from moving forward. By 2015, one of the most determined ALEC-affiliated opponents of Medicaid expansion, former majority floor leader John Diehl, became the Speaker of the Missouri House. Meanwhile in the upper chamber, ALEC claimed three of the five senators who declared that they would filibuster any expansion proposal, and all five of these hard-liners were destined to earn

4. When controlling for the ideological orientation of legislators' constituents, we find that ALEC ties increased the probability of a GOP House member opposing Medicaid by 22 percentage points ( $p = .09$ ;  $N = 74$  GOP House members).



100 percent scores as “Defenders of Prosperity” on the 2014 report card of AFP–Missouri (2014b). Following the ALEC playbook, most Missouri Republicans want to shrink, not maintain or expand, public social spending and services in their state. Indeed, these hard-line conservatives have also overridden vetoes from Governor Nixon to enact other ALEC-endorsed priorities such as large income and corporate tax cuts and right-to-work legislation, further hobbling Missouri’s already weak labor unions.

Of course, whether ALEC affiliated or not, ultraconservative Missouri legislators have little reason to worry about voter backlash, because Republicans in their state are on the rise—and they won the November 2014 elections by supermajority margins. Once a swing state, Missouri has moved decisively to the right in recent years, and both Obama and his health reform law are very unpopular. In August 2010, soon after the Affordable Care Act was signed into law, 71 percent of Missouri voters passed a symbolic referendum against the individual mandate provision in the national law, and they later approved a November 2012 ballot measure blocking a Missouri-run state exchange. Many in Missouri surely approved when the general assembly passed a 2012 law (later overturned in federal court) to allow employers to cite religious reasons to refuse birth control coverage as part of health insurance. A significant number of conservative Missourians may be going without health coverage and watching community hospitals struggle (McBride, Watson, and Blouin 2013), but clear majorities hate “Obamacare” and have not turned against Republican legislators who are obstructing its implementation. Such voter support or acquiescence allows most GOP lawmakers in Missouri to ignore business pressures to accept new federal Medicaid funds.

The push for Medicaid expansion in Missouri continues from a very large number of chambers of commerce, health clinics, hospital associations, professional groups, community associations, and advocacy groups (Yokley 2015). Compromise bills might have a marginally better chance in the aftermath of a May 2015 scandal involving sexting with a college intern that forced the resignation of House Speaker Diehl. The new Speaker, Todd Richardson, does not claim ALEC membership and has not taken such a strong stand against Medicaid expansion (J. Hancock 2015). Nevertheless, the Missouri General Assembly remains chock full of many other staunch opponents. As the editorial board of the *St. Louis Post-Dispatch* (2015) observes, “If facts mattered”—at least the facts about lost coverage and business profits emphasized by proponents —“Medicaid expansion in Missouri would be [a] slam dunk” and would have happened long ago. Conservative legislators see different facts and approach them with the

assumption that any expansion of government social provision is a source of tyranny, high taxes, and fiscal doom. Asked what it would take to move obstructionist Missouri Republicans, Missouri Chamber of Commerce lobbyist and former senator Bond quipped, “Nothing that I know of other than dynamite” (quoted in Cheney and Haberkorn 2014).

Virginia’s fight over Medicaid expansion bears crucial similarities to Missouri’s—featuring a Republican-run legislature standing in the way of broadly supported proposals from a Democratic governor allied with Democratic and some Republican legislators. But Virginia is much closer to partisan parity and attracts more attention from national conservative and liberal forces because it is a swing state in presidential contests. Furthermore, even though there were earlier debates over how to expand Medicaid coverage to some three hundred thousand to four hundred thousand additional poor residents, the decisive battles were delayed until 2014, after Democrat Terry McAuliffe won the November 2013 election to replace term-limited Republican governor Bob McDonnell. Medicaid expansion was a big issue in that election, with McAuliffe promising to adopt it and ultraconservative Republican Ken Cuccinelli pledging with equal fervor to block it. After McAuliffe prevailed in the gubernatorial contest, his newly formed administration, along with many national pundits, took it for granted that Medicaid enlargement would inevitably move forward (Johnson 2013; Weiner 2014a). That is not how it has turned out, however, as various efforts have sputtered to naught from 2013 through the latest legislative session.

The usual broad coalition of expansion supporters came together starting in 2013, spearheaded by more than one hundred health provider organizations, citizens’ associations, and consumer advocates assembled in a coalition called Healthcare for All Virginians (2015) that focuses specifically on closing the health care coverage gap and furthering affordable health care as “an essential element contributing to the common good.” One participant in the coalition is the Virginia Commonwealth Institute, which is linked to both of America’s cross-state networks of center-left policy research organizations. In support of Medicaid expansion, the institute produced briefs, press releases, and blog posts and made the case for expansion to legislators. Like the Missouri Budget Project, the Commonwealth Institute produced a study detailing the budgetary and economic gains expansion would bring to the state (Whorley and Cassidy 2013). It also teamed up with the Virginia Poverty Law Center to spell out potential benefits for each region and legislative district in the state (Cassidy and Hanken 2014). Along with many hospital executives, the Virginia

Hospital and Healthcare Association (2012) lobbied the legislature, touting a commissioned report showing that Virginia would get a \$3.9 billion annual economic boost and support for thirty thousand jobs if it took the federal expansion funds (Martz 2015).

Importantly, in terms of our general model of pro-expansion factors, the Virginia Chamber of Commerce also supported Medicaid expansion (DuVal 2013), although our scale ranks the chamber factor at level 2 out of three levels, because the Virginia general business association did not have a dedicated health policy staffer. A close look at unfolding events in Virginia shows that the state chamber's efforts were sporadic and cautious, carefully focused on boosting bipartisan, market-oriented approaches to expansion, especially the Marketplace Virginia variant put forward in March 2014 by Republican state senator John Watkins (Virginia Chamber of Commerce 2014; McEachin and Watkins 2014). Once compromise efforts failed and partisan battles intensified, the Virginia Chamber of Commerce was not very active. What is more, Virginia's businesses did not speak with one voice, because the state branch of the NFIB declared that stopping Medicaid expansion was its "no. 1 priority," citing opposition to expansion by 81 percent of its fifty-four hundred members responding to an internal poll (NFIB-Virginia 2014b, 2014a). Organized small business opposition was certainly much more unanimous and vociferous in Virginia than in Michigan, and the February 2014 statement from NFIB-Virginia (2014b) praised "the strong legislative leadership of . . . the Republican House Caucus in holding the line against a policy that threatens Virginia's economic stability."

In theory, one relatively smooth route Virginia could have taken to expansion was by way of a recommendation from the Medicaid Innovation and Reform Commission (MIRC), which was included in Governor McDonnell's final 2013 budget (Whorley and Jonas 2015: 7–8). Run by five legislators appointed from Virginia's House of Delegates and five from its state Senate, MIRC had the authority to approve Medicaid expansion for Virginia if its members stipulated that major reforms to the existing state program had been successfully instituted before 2014. Several members appointed from the Senate were open to fulfilling this mission, but the day after MIRC was launched, the Speaker of the House, William Howell, appointed five members from his chamber who were adamant opponents of Medicaid expansion. Although the commission deliberated and convened public hearings (MIRC 2014), it ended up as nothing more than a stalling device and went out of existence after the 2014 legislative session.

After McAuliffe moved into the governor's mansion, Republicans dominated the House of Delegates, but the state Senate was evenly split in 2014 and the Democratic lieutenant governor held a tie-breaking vote. The governor planned to work with Senate supporters of expansion and then press the reluctant House to accept expansion as part of the 2014 budget. Efforts made headway through the inclusion in a Senate budget bill of the Watkins Marketplace Virginia proposal (which Watkins was careful never to label as a "Medicaid expansion"). Republicans in the House were, of course, not fooled, and a majority of delegates stripped the budget of what they called "ObamaCare's Medicaid expansion by a different name" (quoted in Weiner 2014b). Deadlock ensued, and a budget did not get completed in the regular 2014 session. After Governor McAuliffe called a special session to continue consideration of expansion, one of the Democrats in the state Senate suddenly resigned, giving Republicans the majority in that chamber, too (Vozzella and Laris 2014). The Virginia legislature as a whole proceeded to pass a budget without the Medicaid expansion—and it also included a provision to prohibit the governor from carrying through with an earlier threat to pursue expansion through executive action. Yet another special session in late 2014 brought a final vote on another compromise approach to expansion, but it died on a procedural vote in the House by a 64–33 margin. A chastened McAuliffe did not include Medicaid in his 2015 budget proposal, an acknowledgment that legislation cannot move forward until the Senate majority changes.

When we probe more closely into what happened in Virginia, the impact of the prominent conservative networks and organizations becomes clear—including key contributions from the AFP, ALEC, and right-wing think tanks, as well as from assorted state-specific political action committees. For its part, AFP–Virginia (2013, 2014; Novack 2014) ran expensive ads decrying Medicaid expansion; organized rallies and demonstrations, including at one MIRC session; canvassed the districts of Republicans who tried to compromise on Medicaid expansion; and threatened them with primary challenges (Stolberg 2013). Sean Lansing (2014), the state director for the AFP, sent a letter to all members of the general assembly declaring that the "AFP will continue to stand with those who are fighting for the well-being of all Virginians, and we will ensure that citizens have the information they need to hold accountable those who choose to do otherwise."

Conservative think tank experts weighed in at MIRC hearings and provided testimony and reports to Republican legislators looking to derail Obamacare implementation. Interestingly, most of these contributions came

from outside Virginia. One of the state's own SPN-affiliated think tanks, the Thomas Jefferson Institute, produced studies decrying the negative impact of Obamacare on hospitals and small businesses, but the other one, the Virginia Institute for Public Policy, was not very active. Into any potential think tank vacuum came reinforcements from the Cato Institute (Cannon 2014), the National Center for Policy Analysis, and the FGA, whose lead health care expert, Herrera (2013a), presented testimony against Medicaid expansion at an October 21, 2013, MIRC hearing. Later, when it looked as if a compromise might emerge, Herrera arrived again at an April 7, 2014, MIRC hearing in Richmond to comment negatively on the bipartisan Marketplace Virginia proposal.<sup>5</sup> The FGA (2014) also conducted an advocacy poll in Virginia, and Herrera touted the findings in media outlets to raise questions about citizens' support for Medicaid expansion and their willingness to reelect legislators who go along with expansion (Watson 2014).

Herrera is not just any ordinary conservative opponent of Obamacare. Before she moved to the FGA in 2012 she served for seven years as the staff director for ALEC's Task Force on Health and Human Services. There she took the lead in disseminating ALEC model bills for state legislatures to pass—measures intended to weaken regulation of the health care industry, shrink public health spending, and promote privatized, for-profit programs. Yet soon after Herrera (2011) authored ALEC's definitive *State Legislators Guide to Repealing Obamacare*, she moved to the Florida think tank, which gives her more resources and flexibility to fight Medicaid expansion across multiple states, regardless of endorsements from their businesses. Nothing is lost, because even from her new perch at the FGA, Herrera (2013b) has continued to promote anti-Affordable Care Act legislation within ALEC. She is a one-woman anti-Medicaid whirlwind.

Many of Virginia's legislators working to block Medicaid expansion in 2014 no doubt already knew Herrera, so it is not surprising that she and the FGA were invited to offer input at MIRC and other Virginia venues. According to 2013 counts, just over a fifth of Virginia legislators are members of ALEC, roughly the average percentage. Yet as was true in Missouri, pivotal legislative leaders are ALEC stalwarts with a lot of gate-keeping clout (Center for Media and Democracy 2015c). Three out of four top Republican leaders in the Virginia General Assembly are ALEC affiliated, and none has been more critical in the Medicaid battles than Howell, the Speaker of the Virginia House of Delegates, from the twenty-eighth

5. Meeting agendas are available at MIRC 2014.

district near Fredericksburg. A long-serving veteran first elected in 1987 who has held the speakership since 2003, Howell is a former national ALEC chairman who sits on the organization's board of directors. His website boasts that he "has been nationally recognized for his leadership in standing up to Obamacare's Medicaid expansion" and points to a *Wall Street Journal* article praising his ability to keep House Republicans united and defeat Governor McAuliffe (Howell, 2015; Barnes 2014). Indeed, Speaker Howell's obstructive fingerprints are obvious. Howell appointed five firm opponents of expansion to serve as the House of Delegates contingent on MIRC, derailing its capacity to carry out revisions in an enlarged Virginia Medicaid program; he has repeatedly blocked efforts to fashion bipartisan compromises to achieve expansion; and he has kept his Republican colleagues firmly in line for overwhelming party-line votes against any and all expansion bills. And Howell isn't going anywhere anytime soon, because Republicans currently dominate the House of Delegates by a supermajority margin.

Virginia, in sum, shows once again that powerful conservative networks can stymie pro-expansion campaigns even when major business organizations express support. In addition, the ongoing story in the Old Dominion underscores that governors who aim to accomplish Medicaid expansion in divided or Republican-leaning states need a broad array of probusiness allies able to move bills forward within both chambers of the legislature. Failing that, pro-expansion governors must find ways to sideline or get around the legislature altogether.

### Governor Pence Negotiates Expansion in Indiana

Republicans won commanding victories in November 2014, as they did in the previous midterm 2010 contests, and immediately thereafter GOP politicians started gearing up to run for the White House in 2016. With Republicans on a roll and in control of two-thirds of state legislatures, the prospects for additional decisions to expand Medicaid under Obamacare were slim. But the winds seemed to shift when Mike Pence, the governor of the entirely GOP-controlled and quite conservative state of Indiana, announced on January 27, 2015, that he had just concluded an agreement with the Obama administration to extend new Medicaid coverage to 350,000 or more low-income residents through a new version of the state's Medicaid program, the Healthy Indiana Plan (dubbed "HIP 2.0"). To many observers, this seemed a counterintuitive development, because Pence was at the time considered a presidential contender with solid right-wing

credentials. He had been invited to insider confabs run by the ultraconservative billionaire brothers Charles and David Koch; his former chief of staff now heads the Koch funding body known as the Freedom Partners Chamber of Commerce; and the national president of the AFP, Koch confidante Tim Phillips, had called Pence one of his organization's "favorite governors," citing Indiana's tax and regulatory policies as models for other states to follow (Vogel and Haberman 2014). Pence was, quite simply, an improbable sponsor of any sort of accommodation to Obamacare.

More broadly, on the variables stressed throughout this study, the state of Indiana would appear to have been on course for a prolonged standoff between a GOP-dominated legislature and the usual business groups yearning to take more federal Medicaid money. The Indiana Hospital Association (Stimpson et al. 2013) and the Indiana Chamber of Commerce (Wall 2013) both favored market-oriented Medicaid expansion, but they faced likely right-wing pushback. On our index, right-wing networks in Indiana register slightly below average in strength. However, as in Missouri and Virginia, three out of four top legislative leaders in the Indiana House and Senate are ALEC members. They certainly were in a good position to block Medicaid expansion.

Indiana's homegrown right-wing organizations arguably did not go all out to stymie expansion. Chase Downham (2014), the director of Indiana's AFP chapter, issued a firm but low-key statement against Pence's plan for Medicaid expansion, but it is not clear the chapter did much to rally activists in opposition. Possibly Downham pulled his punches because he had previously worked both for Pence and for the Indiana Chamber of Commerce. More likely, the AFP and other right-wing groups in Indiana just did not see clear-cut opportunities to stop Pence.

Think tanks weighed in on the conservative principles at stake. Indiana's own SPN affiliate, the Indiana Policy Review Foundation, was not a major player, but other better-funded and better-staffed think tanks in the nationwide SPN network—including the Heartland Institute in Chicago, the Texas Public Policy Foundation, and the FGA in Florida—did weigh in loud and clear (Archambault, Ingram, and Herrera 2014; Glans 2014). In fact, soon after Pence (2014) gave a high-profile May 2014 speech at the American Enterprise Institute announcing his intention to seek expansion in the guise of "market-based Medicaid reform," Jonathan Ingram and Herrera (2014) of the FGA sent a lengthy memo to all "Indiana legislators and conservative health policy leaders" explaining why any Obama administration approval of Pence's plan would "likely gut the critical elements of the original Healthy Indiana Plan—relegating Gov. Pence's

proposal to Medicaid expansion by another name.” No matter how market-oriented or punitive toward recipients Indiana proposals seemed, conservative experts decried them as too expensive to taxpayers in the long run, just as they decried expansion proposals in other states. Better for the governor and legislators to just “walk away,” Ingram and Herrera (2014) maintained.

This critique might well have inspired members of Indiana’s GOP-run and very conservative legislature to block efforts to expand Medicaid, just as their counterparts did in Missouri and Virginia. But as it turned out, the Indiana legislature did not have to act in any positive way to enable Pence’s HIP 2.0—it just had to sit back and let its very conservative governor negotiate the details of what he always insisted would *definitely not* be any sort of simple “Medicaid expansion.”

Here is how that happened: When Pence assumed office in 2013—after winning the November 2012 election by a commanding margin to replace outgoing Republican governor Mitch Daniels—he inherited Indiana’s unique variant of Medicaid (Gates, Rudowitz, and Artiga 2013). Back in 2007, while Republican president George W. Bush was still in the White House, Daniels had gotten a federal waiver of regular Medicaid rules to launch HIP, which uses private insurers, reimburses hospitals and doctors at generous rates, and requires most poor beneficiaries to contribute on a sliding scale to personal accounts that help pay the costs of their health care. When national health reform came along, Daniels got an authorization in 2011 from the Indiana legislature to start negotiating with the Obama administration about using Medicaid expansion monies for HIP 2.0. Such requests were repeatedly turned down in Washington, but Daniels’s successor Pence kept trying—always consulting with Indiana hospitals and health care businesses about the details of his proposals. Pence also asked the Republican-led legislature to let him keep negotiating HIP 2.0, without enacting any new rules to limit his room for maneuver. Members of the Democratic minority disliked HIP anyway, and Republican leaders deferred to Pence. Many in the legislature—like most observers nationally—probably thought that the Obama administration would never agree to provisions Pence was insisting on, including co-pays for excessive use of emergency rooms and a rule cutting off insurance coverage for six months for beneficiaries who fall behind on monthly contributions to HIP 2.0 (Radnofsky and Campos-Flores 2015).

Contrary to expectations, however, in January 2015 the Obama administration did agree to Pence’s conditions with just a few tweaks (Rudavsky



and Groppa 2015). Without the legislature ever being asked to weigh in, Indiana became the twenty-eighth state to accept Medicaid expansion—of course without admitting it. “I believe Medicaid is not a program we should expand,” Pence declared. “It’s a program that we should reform—and that’s exactly what we’re accomplishing” (quoted in Rudavsky and Groppa 2015). Indiana’s hospitals agreed to collect fees to cover the state’s share after 2016, when the federal subsidy for expansion begins to fall from 100 percent to 90 percent, but they seem happy to do this because Pence’s plan pays providers at much higher rates than normal Medicaid reimbursements. Most players seemed happy with the deal Pence struck (see Indiana Chamber of Commerce 2015)—apart from liberal advocates worried about the precedent of new charges and co-pays imposed on the poor and right-wing pundits who denounced the HIP 2.0 Medicaid expansion as “the worst one yet” (Davidson 2015).

Conservative critics are correct to say that this is a major entitlement enlargement for Indiana. Normally, such critics would have inspired a coalition of ALEC legislators, AFP activists, and SPN-affiliated think tank experts to block any form of Medicaid enlargement in the legislature. But in this instance, the governor did not need any positive endorsement from the legislature, so he could treat Medicaid expansion as a business negotiation.

## **A Concluding Look at Recent State Battles**

Together, our statistical models and case studies confirm previous scholarly findings about the strong impact of partisan control of state governments on Medicaid expansion decisions. Nevertheless, our findings also indicate significant effects on both gubernatorial endorsements and ultimate state decisions from varying degrees of state chamber of commerce support. And our results show that, from 2013 on, counterpressures delivered through intertwined conservative networks run by the AFP, ALEC, and the SPN have been able to checkmate Medicaid expansion even when governors and chambers favor it. Overall, our main statistical model arrives at correct predictions about expansion choices for thirty-seven out of the forty-three states that have made decisions since the end of 2012 (i.e., correct predictions for 86 percent of them).

After the November 2014 elections strengthened Republicans in most states, Medicaid expansion seemed stalled—until Indiana’s move in early 2015 jolted pundits (such as Nia-Malika Henderson [2015]) into predicting that additional GOP states would follow Governor Pence’s lead. But our model suggests that even if governors backed by business allies try to push

**Table 3** Summary Statistics in States with Ongoing Conflicts over Medicaid Expansion

State	Gubernatorial Support	Expansion	Predicted Probability of Expansion (%)	Cumulative Democratic Control, 2013–15	Chamber of Commerce Support Index (0–3)	Right-Wing Network Strength Index (0–1)
AK	Yes	Yes	25	0	1	0.31
WY	Yes	No	6	0	0	0.25
TN	Yes	No	8	0	2	0.66
UT	Yes	No	5	0	2	0.61
MT	Yes	Yes	69	3	2	0.44

forward, many will face fierce ideological pushback. Intra-GOP struggles are exactly what we have seen in three states—Tennessee, Wyoming, and Utah—where Medicaid expansion pushes fell short in 2015, as well as in two other states—Montana and Alaska—where, after fierce fights, expansion is now slated to happen. As indicated in table 3, the 2015 outcomes fit our expectations in all but one case.

Let's take a quick look at the states deciding about Medicaid expansion in 2015, starting with Alaska, where the final decision on July 16, 2015, did *not* correspond to the low probability of expansion generated by our main statistical model. The political drama in the far north nicely fits what we learned about exceptional circumstances from our Indiana case study. In November 2014, Alaskans elected a new governor, Independent Bill Walker, who had defected from the Republican Party and won support from many Democrats (Herz 2015). Walker commissioned a study to document the positive economic impacts of Medicaid expansion (Andrews 2015b) and got backing from the Alaska Native Tribal Health Consortium and the Alaska Chamber of Commerce (2015). But the governor's efforts would not have mattered if the GOP-dominated, very conservative legislature had the final say. During the debate, the AFP's Alaska chapter and the local SPN think tank imported the ubiquitous Herrera from the FGA to present her anti-Medicaid expansion PowerPoints to a crowded public forum with many legislators in attendance (Andrews 2015a; Gutierrez 2015). Alaska's legislature adjourned without bringing expansion bills to the floor (Forgey 2015). But weeks later, Governor Walker invoked a unique provision of the state constitution that allows him to take the federal Medicaid expansion funds without any legislative approval (Herz 2015). As in Indiana and a few other states, unique institutional features allowed

Alaska's governor to act on his own—bypassing the legislative arena in which conservative networks have the greatest clout.

Three other states—Wyoming, Tennessee, and Utah—proceeded true to form by refusing to go along with their Republican governors' recommendations to expand Medicaid.

In deeply conservative Wyoming, legislative debates continued without advancing expansion bills until the 2015 legislature session ended in March (Pradhan and Wheaton 2015). Governor Matt Mead's effort was backed by the state's hospital association and the Wyoming Coalition for Medicaid Solutions, which includes participants "ranging from AARP Wyoming to the Wyoming Business Alliance" (L. Hancock 2015), although the Wyoming Chamber of Commerce did not endorse Medicaid expansion. On the far right, the AFP has no Wyoming chapter, but the SPN-affiliated FGA paid for radio spots opposing the governor's effort (Cunningham 2014). Wyoming legislators probably did not even need that push, because an unusually high 36 percent of them are members of ALEC. In the end, "only 26 of 90 representatives and senators voted for expansion" in the 2015 session (L. Hancock 2015). One Republican senator, Phil Nichols, a supporter, is not optimistic about the future, either, observing, "We don't see big swings in the Legislature. . . . In fact, I'd say some of the newer legislators coming in are more adamant than the older ones about not expanding government programs" (quoted in L. Hancock 2015).

The Tennessee outcome seemed more surprising to many observers. Fresh off a "historically lopsided re-election victory" that saw him prevail in all ninety-five counties and take 70 percent of the vote statewide (Kardish 2015), Republican governor Bill Haslam proposed his own conservative variant of Medicaid expansion, featuring private providers and rules about contributions and penalties for poor beneficiaries (Maloy 2015). Supported by the usual array of consumer advocates, provider groups, liberal researchers, and hospitals, as well as by the Tennessee Chamber of Commerce and Industry (Boyer 2013), Haslam's proposal seemed at first to get a hearing from many GOP legislators—until ultraconservatives swung into all-out opposition. The state's SPN-affiliated think tank, the Beacon Center of Tennessee, touted a study that supposedly proved that "expanding Medicaid will hurt Tennessee families, lower income, and reduce jobs" (Moody 2014), and experts from the FGA penned a *Wall Street Journal* op-ed (Herrera and Owen 2015) declaring that "Gov. Bill Haslam's deal with the Obama administration would cost taxpayers plenty and hurt the neediest people already in the program."

In tandem, AFP–Tennessee mounted a full-scale attack to make sure the legislature, where “ALEC is ingrained,” did not wander astray (quoted in Locker 2015; see also Center for Media and Democracy 2015b). The freshly appointed AFP–Tennessee director was Andrew Ogles, a former GOP operative who had helped the state’s Republicans win supermajorities in November 2014. From his new AFP perch where directors and paid staffers take cues from leaders at AFP headquarters, Ogles did not hesitate to use infusions of national funds to run ads and send district mailers attacking by name the same Tennessee Republicans he had helped elect, when some of them showed interest in Medicaid expansion (Gill 2015; Sher 2015). The attacks worked. As a local journalist recounts (Kardish 2015): “After two days of hearings in February, a state Senate committee handily dispatched Haslam’s proposal, marking the first time a Republican governor had staked so much on a health-care expansion only to be undone by a GOP-controlled legislature. A House committee didn’t even bother taking it up.” Further compromise efforts also came to naught as AFP–Tennessee continued to deploy forty thousand citizen activists and broadcast further ads statewide.

The third no-go for Medicaid expansion in the 2015 legislative sessions happened in very conservative Utah—and counts as more of a fizzle than a hard rejection. Starting in February 2014, Governor Gary Herbert endorsed the idea of Medicaid expansion with reform, and in 2015 he put forward an Indiana-like Healthy Utah plan (Kaiser Family Foundation 2015) that garnered strong support from the important Salt Lake Chamber of Commerce (Beattie 2014) and from a coalition including hospitals called the Utah Health Policy Project. After the Utah House defeated this plan, Herbert started negotiating with key legislative leaders to come up with an acceptable revision (Leonard and Roche 2015). The latest iteration, still in draft form, calls for doctors, hospitals, and other health businesses to pay fees to cover the state’s share of expanded Medicaid after the 100 percent federal subsidy begins to drop to 90 percent starting in 2017. The negotiating process was supposed to conclude with a feasible proposal by July 31, 2015, making it possible for the governor to convene a special late-summer legislative session to get approval for a 2016 expansion. But that deadline has not been met, just as many earlier deadlines have come and gone, leaving many Utah supporters of Medicaid expansion skeptical that expansion will soon move through the legislature (Dickson 2015; Knox 2015; Leonard and Roche 2015). More than most states, Utah’s political culture allows for negotiation and favors respect for leaders, so expansion

may eventually win legislative acquiescence. But the decision is not likely to come to a head until 2016.

The state of Montana, finally, is the one place where a Republican-led legislature approved Medicaid expansion in 2015, fulfilling the expectations of our model. Backed by Democratic governor Steve Bullock, expansion might have happened in the previous regular legislative session in 2013, had not a Democratic legislator cast a mistaken vote on a key procedural matter (Kliff 2013a). After a citizen coalition tried but failed to get a Medicaid expansion initiative on the November 2014 ballot (Dennison 2014), the effort resumed in 2015, when the governor put forward the Healthy Montana Plan to take federal Medicaid expansion funds to pay for privately administered benefits to be extended to seventy thousand poor people. After House Republicans killed the governor's proposal in committee (Whitney 2015), GOP senator Ed Buttrey of Great Falls proposed a compromise that also got broad support. Backing came from the Montana Medical Association, the Montana Hospital Association, unions, and major health plans in the state, including those serving Native Americans (Whitney 2015). Crucially, support was also voiced by the Montana Chamber of Commerce (Carter 2014) and by regional chambers in two major cities, Great Falls and Billings (Great Falls Area Chamber of Commerce 2014: 6; Billings Chamber of Commerce 2014: 3).

Still, as a small but decisive minority of Montana Republicans moved toward compromise, others were adamantly opposed—and the supporters could have been scared off by a suddenly ramped-up right-wing oppositional campaign (Pradhan and Wheaton 2015). Almost one-quarter of Montana legislators are ALEC members, and two out of four majority chamber leaders have ALEC ties. Outside the legislature, moreover, AFP–Montana claims more than eleven thousand citizen adherents (AFP–Montana 2015a), and the organization hoped to replay tactics that worked in Tennessee and Wyoming, by orchestrating paid advertisements and holding demonstrations and critical forums in the districts of Republicans who refused to sign pledges against Medicaid expansion (Scott 2015).

However, in Montana, the AFP made serious missteps. Perhaps the organization's national leaders felt that their long-incumbent Montana director, a former state legislator, was too low-key; or maybe they just hoped to infuse new energy into a suddenly nationally visible Medicaid expansion fight. For whatever reasons, twenty-eight-year-old Zach Lahn was imported from Colorado to direct AFP–Montana. Lahn's only local experience was running 2014 election campaigns for Montana Republicans,

and he often seemed tone-deaf—for example, referring at one point to the “millions of Montanans” who would be hurt by Medicaid, even though the state’s population is barely one million (Strauss 2015). Overlooking prickliness about “outsiders,” Lahn imported anti-expansion speakers from the FGA (Adams, Wipf, and Scott 2015). But things blew up in Kalispell when GOP representative Frank Garner drove hours from the state capital, Helena, to attend the forum and rally his supporters (Scott 2015). Reportedly, hardly anyone said they liked Obamacare, but they did not want outsiders intervening in Montana debates. Similar resistance happened elsewhere.

When push came to shove inside the legislature, supporters of compromise held firm, using elaborate maneuvers to extract a bill from a GOP-led House committee that tried to kill it (Inbody 2015). In the end, enough Republicans felt sufficiently safe to ignore the AFP and defer to local business preferences. Legislation passed the Senate by a 28–21 vote and the House by a 54–46 vote, with thirteen House Republicans joining forty-one Democrats in support (Dennison 2015). At the end of April 2015, Bullock signed expansion into law, putting Montana on the road to enlarge Medicaid for 2016, assuming that federal authorities approve key provisions. A month after it failed to stop Montana’s Medicaid expansion, the AFP moved on from its young imported director, appointing a replacement touted as a “fifth-generation Montanan” (AFP–Montana 2015b). The state’s Medicaid expansion plan still faces a tricky implementation process overseen, in part, by conservative Republicans in the Montana legislature, and the AFP is not giving up the fight.

That seems a fitting note on which to end this article. Once the Supreme Court ruled in June 2012 that Medicaid expansion under the Affordable Care Act would be optional for states, it set the stage for many battles, not just between the two major political parties but within and around the Republican Party. Using a combination of quantitative and qualitative evidence and methods of analysis, we have established that contending organizations and networks are one key place to look to understand how the critical choices about Medicaid expansion are playing out across the fifty US states. More remains to be learned and measured about how such organizations and networks achieve impact, but we have made a solid start. Further efforts are bound to pay off, because the clash of business organizations and ideological networks drives much of what happens in this ongoing Republican civil war over the implementation of health reform.

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**Alexander Hertel-Fernandez** is a PhD candidate in government and social policy at Harvard University and a graduate fellow in the Multidisciplinary Program in Inequality and Social Policy at the Harvard Kennedy School. His research focuses on the political economy of public policy in the United States, and his dissertation examines the development of coalitions between conservatives and business groups across the states since 1973.

**Theda Skocpol** is the Victor S. Thomas Professor of Government and Sociology at Harvard University and director of the Scholars Strategy Network. Her research focuses on US civic life, politics, and public policy making. She is the author of *Health Care Reform and American Politics* (2010), coauthored with Lawrence R. Jacobs, about the enactment of the Affordable Care Act of 2010.

**Daniel Lynch** recently graduated from Harvard College, where he served as associate managing editor of the *Harvard Political Review* and completed a senior thesis on spending and advertising in US Senate races. He is now a first-year student at Harvard Law School.

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