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# POLICY AND POLITICAL MOTIVES FOR MEDICAID EXPANSION UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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# POLICY AND POLITICAL MOTIVES FOR MEDICAID EXPANSION UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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## Objective

This study aims to analyze policy-related and political rationales for Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA). More specifically, this study seeks to discover whether states' decisions regarding Medicaid expansion were likely based on policy implications regarding the uninsured or political motives.

## Methodology

The approach is a cross-sectional/observational study of American states and the District of Columbia after the *Sebelius* decision in 2012. This study compares three variables: (1) whether each state decided to opt into the expansion ("Opted In"), (2) whether each state's governor and legislature were affiliated with either the Democratic or Republican party at the time of its decision ("Party"), and (3) the potential impact of Medicaid expansion on the uninsured population of each state ("Uninsured"). "Opted In" is the dependent variable; "Party" is the political variable; and "Uninsured" is the policy variable. This study utilized analysis of variance (ANOVA), chi-squared testing, and hypothesis testing between statistics to analyze relationships between variables.

## Results

For the study sample (N = 38), data analysis found statistically significant relationships between: (1) uninsured rates and decisions regarding Medicaid expansion; (2) political party affiliation and decisions regarding Medicaid expansion; and (3) political party affiliation and uninsured rates in respective states. States with higher rates of uninsured citizens were less likely to opt into the Medicaid expansion. Republican states were less likely to opt into the expansion than Democratic states. Democratic and Republican states had statistically different rates of uninsured citizens, with Republican states having higher rates than Democratic states.

## Conclusion

Results suggest both policy and political motives influence executive and legislative decision-making. The direction of influence of policy implications regarding the uninsured is inconsistent with PPACA's policy goal of reducing the uninsured population. However, Republican states have higher rates of uninsured citizens than Democratic states. Therefore, inconsistencies may be incidental to overall political influence and social structure within states. Greater public health advocacy may help to overcome political barriers to achieving the policy goals of legislation.

## Introduction

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA).[1] Two central provisions of PPACA were the individual mandate, which requires every citizen to acquire minimal health insurance or face a payment requirement to the IRS, and the Medicaid expansion, which extends eligibility for Medicaid to those who fall under 138% of the federal poverty level.[2-3] Furthermore, PPACA declared that every state must opt into the expansion or forfeit the entirety of their Medicaid funding from the federal government.[3] Leaning on constitutional limitations and Tenth Amendment rights, numerous states and private sector organizations opposed PPACA and brought suit in federal district court to challenge the constitutionality of the individual mandate and the Medicaid expansion.[4] The Supreme Court of the United States granted certiorari to hear the case and came to the determination that the individual mandate is constitutional under Congress's power to tax.[4] However, the Supreme Court declared that the federal government could not compel states to adopt a federal regulatory program like Medicaid.[4] The coercive nature of the provision led the Supreme Court to declare the Medicaid expansion as unconstitutional.[4]

In a dissenting opinion, Justice Ginsburg emphasized the underlying policy of PPACA—to assist over 50 million Americans who lack health insurance and to reduce the nation's overall rising health care costs—and concluded that the Medicaid expansion provision requires states to do what they have always done; namely, to continue to comply with the conditions Congress has set forth to receive Medicaid funds.[4]

Considering such, Justice Ginsburg viewed the Medicaid expansion as constitutional under Congress's power to spend, despite the majority declaring otherwise.[4-5]

As evident in a divided Supreme Court regarding the issue of the constitutionality of the Medicaid expansion, perspectives vary as to whether the provision served as a condition for funding (constitutional) or a coercive restriction on states (unconstitutional). Perhaps policy concerns, balanced against constitutional limitations, play a role in shaping such perspectives and placing the provision along the continuum of constitutionality. In other words, policy may influence decisions to embrace legislation. Additionally, all current Supreme Court Justices appointed by Republican administrations viewed the Medicaid expansion—proposed by a Democratic administration—as coercive and unconstitutional.[1, 6-7] The only Justices in support of the provision's constitutionality were appointed by Democratic administrations.[6-7] Thus, while exceptionally impartial, almost all Supreme Court Justices' perspectives align with their respective party in regards to Medicaid expansion under PPACA. In other words, political motives may influence decisions to embrace legislation. This study aims to shed light on whether, and to what extent, policy and political motives play such a role at the state level.

Following *Sebelius*, states had the decision whether to opt into the Medicaid expansion outlined in PPACA, develop an alternative plan—subject to federal approval—to expand health insurance coverage under Medicaid, or do neither.[8] This study will analyze states' decisions and whether they were likely made based on policy implications regarding the uninsured or political motives. In theory, the Medicaid expansion had the capacity to provide health insurance to millions of Americans who fall under 138% of the federal poverty level.[3] If states relied on policy implications regarding

the uninsured in their decision whether to opt into the expansion, states with a greater percentage of uninsured citizens would be more likely to opt in. However, given that PPACA was enacted by a Democratic administration, states might have ignored the strong policy reasons for opting in— including providing affordable health insurance to eligible citizens—and chosen to opt out based on political reasons.[9]

Advocates of public health who believe in the fundamental principle that health is a human right would like to see states opting into the expansion because doing so would significantly reduce the percentage of uninsured citizens.[4, 10-11] While health insurance does not guarantee health, it provides coverage which allows access to care; access to care promotes health.[12-15] Nonetheless, political motives, such as resisting enactments by an opponent party, may put up barriers to health care—a fundamental human right.[9-11]

This study will compare three variables: (1) whether each state decided to opt into the expansion ("Opted In"), (2) whether each state's governor and legislature were affiliated with either the Democratic or Republican party at the time of its decision ("Party"), and (3) the potential impact of Medicaid expansion on the uninsured population of each state ("Uninsured"). Ultimately, this study aims to answer two questions with respect to Medicaid expansion under PPACA. First, is there a relationship between policy considerations and executive or legislative decision-making in states? Second, is there a relationship between politics and executive or legislative decision-making in states?

The proposed study is complicated by the tremendous array of factors that influence executive and legislative decisions in states—such as whether to opt into the Medicaid expansion under PPACA. In reality, variable interactions and omitted variables

probably play a role in decision-making outcomes. Nonetheless, this study aims to analyze the two most likely influences—the potential impact on the uninsured and party affiliation—on decisions, potentially driven by policy or politics, regarding Medicaid expansion. Ultimately, this study may reveal a greater need for public health advocacy in order to overcome political barriers to achieving the policy goals of legislation.

The following analysis includes a comprehensive review of literature pertaining to public health, law, and politics. Each topic plays a fundamental role in establishing an understanding necessary to conduct a study and interpret results in regards to Medicaid expansion under PPACA. Following, data analysis will potentially answer whether, and to what extent, policy or political motives influence executive or legislative decision-making.

## Literature Review

The following review of literature summarizes key concepts foundational to understanding the complexity of states' decisions regarding Medicaid expansion under PPACA. It represents theoretical and empirical knowledge gathered from the disciplines of public health, law, and politics. Cited works come from books, book chapters, journal articles, conference papers, and other scholarly publications within the following databases and sources: the ACA Implementation Research Network, The Commonwealth Fund, EBSCO, Google Scholar, Grey Literature, Health Affairs, LexisNexis, the National Academy for State Health Policy (NASPH), The Pew Charitable Trusts, PubMed, RAND, and Urban Institute. The search process utilized the following words and phrases: healthcare reform; Patient Protection and Affordable Care Act; uninsured populations; health care expenditures, quality, and performance; individual mandate; Medicaid expansion; health care coverage; access to care; health care outcomes; prevention; cost savings; the paradox of prevention; *Sebelius*; constitutional law; federalism; Tenth Amendment rights; the Taxing and Spending Clause; legislative history of PPACA; support for PPACA; opposition to PPACA; state government decision-making; political party influence; voting habits; 1115 waivers; subsidized insurance; public choice; economics; budget shortages; cost sharing; fiscal capacities; per capita spending; and factors affecting political embrace of legislation. Additionally, the following review will analyze material cited within works obtained from the search process.

The first portion of this literature review focuses on public health. It describes the American healthcare system and the need for reform, and public health's role in addressing the health status of the population. Policy—including public health policy—

guided the reform and gave life to PPACA. The second portion focuses on law. Law served as the vector for states to challenge PPACA. Additionally, law prompted states to decide whether to embrace PPACA. The third portion focuses on politics. Politics likely guided states in making their decisions. In short, these three disciplines all fit together in the puzzling world of Medicaid expansion: PPACA arose from policy; it was challenged in law; law set the stage for politics to operate. The literature review concludes by briefly summarizing what is known and unknown about policy and political motives for Medicaid expansion in states and articulating this study's limitations as well as contributions to the field.

## PUBLIC HEALTH

### *The American Healthcare System and PPACA Implementation*

In years prior to the major insurance provisions of PPACA, health status within the United States, and in states such as Kentucky, was less than remarkable. In 2013, the United States ranked 37th in the world with respect to health care performance.[16] The United States' poor ranking elevates to abysmal considering it spent more on health care than any other country in the world.[17] In fact, the United States spent twice as much per capita as the next highest spending country. However, quality of care and life years within the United States ranked significantly lower than many countries that spent less per capita on health care.[18]

Many factors contribute to the poor performance and quality of the American healthcare system as well as the increased costs it incurs, including lack of coverage. Leading up to the healthcare reform under PPACA, approximately 1 in 5 Americans did

not have health insurance.[19] Thus, a massive proportion of the American people may not have utilized health services due to shortcomings in coverage. Such shortcomings translate to reduced access to care.[13] Avedis Donadebian, a physician and respected leader in quality assessment, defined lack of access in itself as poor quality.[20] Evident in a shift of focus from treatment of acute and chronic conditions to primary care and preventive efforts, those uninsured Americans who did seek health services likely sought costly emergency services as opposed to cheaper preventive options.[21] In other words, uninsured Americans sought treatment when they were sick. That type of treatment is costlier than preventive efforts and, therefore, contributes to the rising costs of health care.[21]

In response, the American political system began efforts through policy development to improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care.[22] PPACA came to life.

***Policy of PPACA***

Signed into law by President Obama in 2010, the Patient Protection and Affordable Care Act (PPACA) aims to shift focus from treatment of acute and chronic conditions to primary care and preventive efforts. PPACA, in general, aims to assist the 50 million Americans who lack health insurance and reduce the nation's overall rising health care costs.[4] It has two main provisions to accomplish those policy goals: (1) the "individual mandate" and (2) the "Medicaid expansion" provisions.[2-3] The individual mandate provision requires every citizen to acquire minimum health insurance or face a payment requirement to the IRS.[2] The Medicaid expansion provision extends eligibility for Medicaid to those who fall under 138% of the federal poverty level.[3]

Both provisions seek to assist the vast population of uninsured Americans in obtaining health insurance. Specifically, the payment requirement for not having minimum health insurance under the individual mandate provision incentivizes Americans to obtain health insurance. However, some Americans may not have the resources to obtain such insurance due to an inability to pay for more expensive options and ineligibility for cheaper options. The Medicaid expansion provision assists those Americans by extending eligibility for Medicaid to those who fall under 138% of the federal poverty level. The expanded eligibility has the capacity to allow for coverage of 16 million previously uninsured Americans and 400,000 previously uninsured Kentuckians.[23]

In theory, providing health care coverage to millions of Americans who lacked health insurance would facilitate access to care and improve the performance and quality of the American healthcare system.[4] While health insurance does not guarantee health, it provides coverage which allows access; access to care promotes health.[12-15] Thus, expanded coverage would allow a massive population of uninsured Americans to seek care—specifically, primary care and preventive services. Upstream action would keep more and more Americans healthy and address the health status of the population.

PPACA, therefore, is a product of public health policy—characterized by a focus on preventive and upstream action to address the health of the population. The public health policy of PPACA would serve as a foundation to improve the health status of the population.

### *The Paradox of Prevention*

The "paradox of prevention" describes a potential obstacle for spectators of American healthcare reform to realize whether the policy goals of PPACA come to fruition. In turn, the paradox of prevention may deter support for both PPACA and future legislation.

The paradox of prevention essentially says that the results of preventive efforts are not appreciated because they go unnoticed, are not dramatic, and take a long time to come to fruition.[24-25] How do we quantify what never happened? What do we have to show for our efforts? For spectators of American healthcare reform to appreciate reform efforts, they must *see* results. To *see* results, people must first need care. Thus, people must first get sick. However, the policy underlying PPACA focuses more on preventive efforts to keep people from getting sick. In theory, if PPACA works, difficulty will arise with respect to quantifying improved health outcomes. For example, it is far easier to quantify cancer treatment outcomes than it is to show how many people would have gotten cancer but did not due to preventive efforts. As a result, the fruits of the preventive efforts go unnoticed and, therefore, unappreciated. Lack of appreciation decreases support for PPACA and future related legislation. Decreased support hurts political agendas. The paradox, therefore, captures the difficulty public health advocates face in the political world—a world that thrives from clearly identifiable and quick results, and support from constituents.

### *Health as a Human Right*

Despite the tremendous political barriers obstructing the policy agenda, public health efforts ensue, achieving and maintaining health for all. Advocates of public health

believe in the fundamental principle that health is a human right.[10-11] In the context of Medicaid expansion, public health advocates would like to see states opting into the expansion because doing so would significantly reduce the percentage of uninsured citizens.[4] At a broader level, opting into the exchange would provide coverage to millions of Americans which allows access to care; access to care promotes health—a fundamental right in the world of public health.[10-15]

## LAW

### *NFIB v. Sebelius*

Leaning on constitutional limitations and Tenth Amendment rights, numerous states and private sector organizations opposed PPACA and brought suit in federal district court to challenge the constitutionality of the individual mandate and the Medicaid expansion.[4] The Supreme Court of the United States granted certiorari to hear the case and address the issue of whether Congress has the authority under the Constitution to enact the individual mandate and the Medicaid expansion provisions.[4]

The Supreme Court came to the determination that the individual mandate is constitutional under Congress's power to tax.[4] However, the Supreme Court declared that the federal government could not compel states to adopt a federal program like Medicaid.[4] The coercive nature of the provision led the Supreme Court to declare the Medicaid expansion as unconstitutional.[4]

Following *Sebelius*, states had the decision whether to opt into the Medicaid expansion outlined in PPACA, develop an alternative plan—subject to federal

approval—to expand health insurance coverage under Medicaid, or do neither.[8] Politics likely guided states in making their decisions.

## POLITICS

"When we say that policies are decided by analysis, we mean than an investigation of the merits of various possible actions has disclosed reasons for choosing one policy over others. When we say that politics rather than analysis determines policy, we mean that policy is set by the various ways in which people exert control, influence, or power over each other."[26]

### *Legislative History of PPACA*

A Democratic administration developed and enacted the Patient Protection and Affordable Care Act (PPACA).[1] Not surprisingly, PPACA saw support from many Democratic constituents and opposition from Republicans. For example, former Governor Steve Beshear—a Democratic governor in Kentucky—released a statement describing PPACA as the "single-most important decision in our lifetime for improving the health of Kentuckians."[27] To the contrary, various Republican governors including Rick Perry—the governor of Texas—took an early stance against PPACA.[28] Governor Perry expressed a desire to reform Medicaid on "Texas' terms," describing the "crushing" weight of Medicaid costs on Texas infrastructure.[29] Texas is among many other states that enacted laws to oppose the insurance mandates and reform policies of PPACA.[30]

Clearly, a broad continuum of perspectives on healthcare reform exists. Perspectives emphasize desires to improve the health status of the population, reveal

concerns for costs, and raise issues about the autonomy of states in America's federalist scheme. Across all perspectives shines a political gleam. A cursory assessment of the landscape of healthcare reform reveals a political divide. While not absolute, Democrats predominately express the most support for PPACA. Consistently, Republicans predominately display the most opposition to it. Proponents of PPACA and its underlying public health policy emphasize its tremendous capacity to improve the health status of the population. Opponents focus more on its financial requirements and principles of federalism and Tenth Amendment rights; specifically, fiscal capacity to absorb Medicaid costs and state autonomy from the federal government.

***Executive and Legislative Decisions at the State Level Regarding PPACA***

The implementation and progression of PPACA and Medicaid expansion in Kentucky aptly captures the relationship between policy and politics in the arena of healthcare reform in the states. Following implementation of PPACA in 2010, former Democratic Governor Steve Beshear utilized an executive order to expanded coverage under Medicaid and establish a state health benefit exchange referred to as "kynect."[31] Spectators of American healthcare reform often considered Kentucky the "gold standard" of implementing healthcare reform under PPACA. Kentucky's expanded coverage and state health benefit exchange allowed for the coverage of hundreds of thousands of Kentuckians—significantly reducing the uninsured population. Despite Kentucky's unique success in advancing the policy goals of PPACA, newly elected Republican Governor Matthew Bevin announced his plans to uproot the exchange and rollback the expanded Medicaid beneficiaries to the federal exchange—costing the commonwealth money and significant administrative resources. Upon election, Governor Bevin

rescinded former Governor Beshear's executive order, delivering the death nail to kynect. Nonetheless, the Governor announced his Medicaid waiver proposal which, if approved, would restore coverage to those who lost it through the repeal of kynect.[32]

Former Governor Beshear adamantly supported PPACA and elected to shepherd its implementation in Kentucky through expanded coverage and a state health benefit exchange. By doing so, former Governor Beshear advanced the policy goals of PPACA of assisting uninsured citizens in obtaining health insurance. However, Governor Bevin—a Republican governor—decided to ignore the success of Kentucky in the national landscape of healthcare reform and repeal the state exchange. In doing so, Governor Bevin put Kentucky in a position to incur costs to rollback the expanded Medicaid beneficiaries to the federal exchange and deplete administrative resources. Considering Kentucky's tremendous enrollment success, it seems only compelling reasons should prompt executive or legislative action to reconsider Kentucky's efforts in healthcare reform. The question then arises why Governor Bevin elected to rescind the former Governor's executive order. A likely explanation is politics. By uprooting kynect, Governor Bevin created an opportunity for the Republican agenda to guide healthcare reform in Kentucky. This opportunity took the form of a 1115 waiver referred to as "Kentucky HEALTH" which the Governor unveiled in a press conference on June 22, 2016.[32] Kentucky HEALTH pleases Republican constituents who wish to see the Republican agenda guiding efforts in Kentucky. Moreover, the 1115 waiver still expands Medicaid coverage which may please the citizens who otherwise would have lost coverage eligibility after the repeal of kynect. With respect to expanded coverage, the Governor is advancing the policy goals of PPACA. Although, the section 1115 waiver to

the federal Democratic enactment implicates a political resilience to embracing the legislation.

In summary, policy and political motives likely influence executive and legislative decision-making in states.

***State Government Decision-Making***

An overview of the decision-making process in states is essential to understand the complexity of states' decisions regarding Medicaid expansion under PPACA. Major players in state government include the governor—the head of the executive branch—and the legislature—the core body of the legislative branch.[33] Generally, legislatures develop legislation which it may then pass to the governor to sign into law. The governor may also enact laws via executive orders which occurs primarily when the legislature is not in session. Executive orders allow governors to bypass the legislative process. The governor and the legislature do not have to affiliate with the same political party. If the governor and legislature affiliate with different parties, that state is referred to as a "split-party" state. Split-party states may encounter issues in advancing respective political agendas due to conflicting interests.[28, 34] Moreover, all members of the legislature in each respective state typically do not affiliate with the same party. Overall political affiliation of a legislature is determined by the party that preponderates the legislature's composition.[35]

With respect to healthcare reform under PPACA, different avenues for decision-making and dynamics of party influence may result in cooperation or disjoint between the governor and legislature of each state.[28] Understanding these dynamics helps to make

some sense of the complexity of states' decisions regarding Medicaid expansion under PPACA.

***Political Party Influence***

Clear evidence of political party influence can be elusive. The ideological nature of politics makes it difficult to quantify political influence. Ideas and opinions make up politics. Ideas and opinions are subjective and difficult to quantify. Nonetheless, studies have attempted to determine how political party influence affects decision-making.

A 2003 study in the Journal of Personality and Social Psychology found that attitudes towards a policy depend almost exclusively on the stance taken by one's political party. The study went on to prioritize (1) the impact of political party influence, (2) objective assessment of the policy, and (3) the subjects' ideological beliefs and found political party influence overwhelmed the latter two influences with respect to decision-making.[36] This study finds that political party influence greatly affects one's decision-making process. Typically, an individual's decisions will align with the stance taken by the political party with which they affiliate. An article on estimating party influence in congressional roll-call voting reached a similar conclusion, quoting "[v]irtually all studies . . . find that political party affiliation is one of the best predictor of voting behaviors."[37]

Another layer of political influence exists with respect to the "range of politics." The range of politics refers to the degree of alignment with a particular issue on a continuum ranging from one extreme to another. For example, an anti-abortion extremist may have the belief that abortion is never acceptable, under any circumstances. A moderate party may have the belief that abortion is generally unacceptable, except under certain circumstances. Both parties oppose abortion. However, the first party opposes

abortion in a more extremist fashion than the second party. Any number of factors may shape how individuals align with certain issues. One study suggests that lack of understanding of complex policies accounts for polarization to a particular extreme.[38] Following this study's findings, polarization to one extreme or another with respect to healthcare reform may come about due to a lack of understanding of the complex policies underlying PPACA. In which case, advocacy and education may prove beneficial.

In the world of extremist and moderate politics in healthcare reform, Ohio presents an interesting case study. The governor of Ohio—Governor Kasich—affiliates with the Republican Party.[39] However, Governor Kasich classifies as a "moderate" with respect to many issues, including healthcare reform. In fact, under Governor Kasich's leadership, Ohio embraced the traditional Medicaid expansion outlined in PPACA.[39]

States also have the option of submitting a 1115 waiver—subject to federal approval—to employ an alternative plan to expand coverage.[40] Through 1115 waivers, states may still expand coverage under Medicaid but bypass the traditional expansion under PPACA. Utilizing this process may implicate more of an attention to policy than political resilience considering it results in expanding coverage. Still, this process may also implicate political resilience since it allows states to subsidize private insurance, not necessarily Medicaid under PPACA. Section 1115 waivers, therefore, fall into an inexplicable nebulous with respect to deciphering the policy and political motives for Medicaid expansion in states under PPACA.

***Economics, Budget Shortages, and Cost Sharing***

In addition to political party influence, principles of economics may direct politics and decisions whether to embrace legislation.[34] In a discussion regarding economics and

public policy, the distinguished Dr. Merl Hackbart of the University of Kentucky Martin School of Public Policy and Administration said, "in politics, 'the future is tomorrow.'"[41] Dr. Hackbart described how governments typically operate by seeking immediate results. This principle opposes the long-term nature of public health goals.[42] Thus, a tension exists between politicians and public health advocates when deciding whether to embrace legislation that has both short- and long-term effects.

In the context of healthcare reform, expanding Medicaid will provide coverage eligibility to millions of Americans. Health care coverage may allow access to health care—a promotor of health outcomes. Moreover, PPACA emphasizes primary care and preventive efforts. Such efforts would make and keep the population healthier and, therefore, reduce the need to pay for costly services to treat acute and chronic conditions. In turn, the American healthcare system may see long-term cost savings and a reduction in the nation's overall health care costs. However, according to Dr. Hackbart, politicians act with a more immediate focus. Thus, the short-term effects of cost may overshadow the long-term investments. As a result, the public health agenda may fail when facing the political agenda. For instance, expanding Medicaid requires resources. Some states may not have the resources to support expansion.[29] Immediate budgetary concerns may, therefore, account for an inability to embrace PPACA and advance its policy goals.

Furthermore, cost sharing and other financing likely influence decisions to embrace PPACA. The federal government and states jointly fund the Medicaid program. Wealthier states are required to pay a larger percentage of overall funding than poorer states. Additionally, PPACA provides for a stepwise decrease in federal funding. Thus, over the years, state financing obligations will increase. Some states may have difficulty

in meeting the financial demands to keep Medicaid functioning. In other words, it may be too costly to expand Medicaid. States—especially states with a massive uninsured population—may not have the fiscal capacity to absorb Medicaid costs.[43-44] Additionally, states can choose how they allocate their budget. Some states may choose to invest more per capita on programs such as education, which may leave only limited resources for health care and programs such as Medicaid. As previously noted, Governor Rick Perry of Texas expressed a desire to reform Medicaid on "Texas' terms," describing the "crushing" weight of Medicaid costs on Texas infrastructure.[29] Texas infrastructure may vary considerably from that of other states and, therefore, require attention to different programs to meet its needs. In other words, some states may designate health care as a lower priority than other programs and, therefore, choose not to expand Medicaid due to spending concerns.[44]

**SUMMARY**

Prior to the major insurance provisions of PPACA, the United States healthcare system was characterized by poor performance and quality. Additionally, America spent more on health care than any other country in the world. In other words, America invested a lot of resources only to not get results. A vast population of Americans did not have health care coverage. As a result, many Americans did not have access to health care—a promotor of health outcomes. To address these issues, the Obama Administration developed the Patient Protection and Affordable Care Act (PPACA).

PPACA focuses on primary care and preventive efforts, effectively incentivizes obtaining health insurance, and extends coverage eligibility to an additional 16 million

Americans. Extending coverage may allow millions of Americans to access health care. Access to care may, in turn, promote health.

PPACA is a product of public health policy—characterized by a focus on preventive and upstream action to address the health of the population. The public health policy of PPACA serves as a foundation to improve the health status of the population and to achieve the goals of PPACA. However, if public health policy achieves its goals, the nation will not notice it according to the paradox of prevention. Nonetheless, efforts ensue considering public health advocates believe that health is a human right. PPACA allows millions of Americans to have coverage and, in turn, access to health care. Under PPACA, millions of Americans may see better health outcomes. In summary, PPACA comports with public health policy and aims to improve the health status of the population.

Despite compelling public health policy reasons to embrace PPACA, many states and others opposed PPACA and sought to strike down its key provisions. With respect to the Medicaid expansion provision, opponents partially succeeded in a favorable Supreme Court decision in *Sebelius* which gave states the choice whether to opt into the Medicaid expansion outlined in PPACA, develop an alternative plan—subject to federal approval—to expand health insurance coverage under Medicaid, or do neither. Politics likely guided states in making their decisions.

In the world of politics, party affiliation and economics likely play the greatest roles. Most opposition to legislation comes from parties that did not develop it. This suggests that parties will resist enactments by their opponent parties. Despite policy rationales, political motives may guide executive and legislative decision-making.

America's bipartisan system of government creates a divide and introduces barriers to achieving the policy goals of legislation. For example, since a Democratic administration enacted PPACA, it makes sense politically for Democratic states to embrace PPACA and Republican states to oppose it even if policy supports a different outcome. In short, states may not adequately consider policy during the executive or legislative decision-making process.

In the context of Medicaid expansion under PPACA, economics may somewhat explain decision-making in states. A state may consider how Medicaid expansion will affect its budget in coming years. States may assess whether they have the fiscal capacity to absorb Medicaid costs when federal funding incrementally decreases and places more of a financial responsibility on states through cost-sharing ratios. States may choose to invest more per capita on programs other than Medicaid and, therefore, choose not to expand Medicaid due to spending concerns. This study merely discusses economics conceptually.

***Limitations***

Along with party affiliation and economics, a tremendous array of factors influences executive and legislative decisions in states. In reality, variable interactions and omitted variables probably play a role in decision-making outcomes. However, due to the extraordinary complexities in the national landscape of healthcare reform, this study does not adjust for state economic factors, cost sharing ratios, per capita spending, demographics, sociological factors, racial bias, or other factors that vary across the nation. This study takes a limited approach to target certain variables of interest and reveal potential relationships at a broad level. Thus, findings may be confounded.

Nonetheless, this study aims to analyze the two most likely influences—the potential impact on the uninsured and party affiliation—on decisions, potentially driven by policy or politics, regarding Medicaid expansion.

***Contributions to the Field***

In politics, "the future is tomorrow." This mantra contrasts the long-term nature of public health goals. Thus, a tension exists between politicians and public health advocates when deciding whether to embrace legislation that has both short- and long-term effects. Politicians, voters, and all else must understand both the short- and long-term effects of legislation. Maybe then, more people will understand the need to promote health and how public health can achieve that goal. This paper serves as a bridge between public health and law regarding policy and politics. Principles identified and discussed in this paper may prove useful when analyzing future legislation. Ultimately, this study may reveal a greater need for public health advocacy in order to overcome political barriers to achieving the policy goals of legislation.

# Methodology

This is a cross-sectional/observational study of American states and the District of Columbia after the *Sebelius* decision in 2012. As previously discussed, this study compares three variables: (1) whether each state decided to opt into the expansion ("Opted In"), (2) whether each state's governor and legislature were affiliated with either the Democratic or Republican party at the time of its decision ("Party"), and (3) the potential impact of Medicaid expansion on the uninsured population of each state ("Uninsured"). "Opted In" serves as the dependent variable; "Party" serves as the political independent variable; and "Uninsured" serves as the policy independent variable. This study utilizes analysis of variance (ANOVA), chi-squared testing, and hypothesis testing between statistics to analyze relationships between variables. Specifically, this study compares the "Opted In" variable with both the "Uninsured" and "Party" variables, as well as the "Party" variable with the "Uninsured" variable. Ultimately, this study aims to answer two questions. First, is there a relationship between policy and executive or legislative decision-making in states? Second, is there a relationship between politics and executive or legislative decision-making in states?

***Research Methodology***

The "Opted In" variable is dichotomous. A value of 1 indicates that a particular state opted into the expansion or developed an alternative plan to expand health insurance coverage, and a value of 0 indicates a particular state chose not to expand Medicaid. Information necessary to assign such values comes from the Kaiser Family Foundation (KFF), according to information from the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS), and the National

Academy for State Health Policy (NASHP).[39, 45-46] KFF, DHHS, CMS, and NASHP directly deal with the issue at hand and therefore have valid and reliable information regarding state health insurance exchanges. Table 1 portrays data for the 50 states and the District of Columbia.

The "Party" variable is dichotomous. A value of 1 indicates a particular state's governor or legislature affiliated with the Democratic Party at the time of its decision regarding Medicaid expansion. A value of 0 indicates affiliation with the Republican Party. CMS has not imposed a deadline for deciding to expand coverage under PPACA or through an alternative plan.[47] Therefore, data for party affiliation of each state's governor and legislature must correspond to the year in which each state made a decision regarding Medicaid expansion. Necessary data is recorded under the "Year of Decision" column in tables 1 and 2. Furthermore, the method for each decision dictates whether the party affiliation of the governor or legislature of each state is used for analysis. For example, some states employed a process through which the legislature developed and approved legislation for the Governor to sign into law.[39, 48-49] Other states, such as Kentucky, embraced or rejected PPACA via executive orders that did not require approval by its legislature.[39, 48-49] With respect to data gathering, states that employed the latter are denoted "Exec" on tables 1 and 2 under the "Executive/Legislative" column. States with legislative enactments are classified "Exec/Legis". Party affiliation reflects the party affiliation of the branch that effectuated each state's decision in the respective year up through 2016, if party affiliation differs between the governor and legislature.[35] If the state was a split-party state and the method of decision-making did not involve an executive order or if that state has decided not to expand Medicaid, that state receives no

value for the "Party" variable, considering the balance of party influence. If the state's governor and legislature affiliated with the same party, data for that dominant party for that year is used. For states that expanded coverage, data for decisions and party affiliation are up to date through 2016. Additionally, data for party affiliation in states that have decided not to expand Medicaid reflect the 2013 year—the year after *Sebelius* when the majority of states made decisions regarding expanding coverage.[35, 50] The National Conference of States Legislatures (NCSL) for 2013 and respective years of states' decisions have the necessary information to assign values for the "Party" variable in tables 1 and 2.[35, 50] The NCSL possesses valid and reliable information pertaining to executive party affiliation and political party control of state legislatures for each year. Table 1 portrays data for the 50 states and the District of Columbia.

"Uninsured", a continuous variable, quantifies the potential impact expanding coverage could have on uninsured populations by measuring the percentage of uninsured citizens in each state. That measure requires several assumptions. First, uninsured rates—prior to expansion—remain relatively constant. CMS has not imposed a deadline for deciding to expand coverage under PPACA or through an alternative plan.[47] Additionally, the percentage of uninsured Americans in each state is taken at a point in time—2013, the year following *Sebelius*.[19] In the timespan states may implement PPACA or alternative plans for expanding coverage, percentages of uninsured Americans may vary from the values for 2013. Still, the majority of states that made decisions to expand coverage did so in 2013. Table 1. Therefore, data from 2013 is used. Second, the expansion would result in coverage of uninsured citizens. It is possible the same individuals eligible for coverage after the expansion would refuse to enroll and accept the

payment requirement to the IRS.[2] Third, the expansion will primarily affect the uninsured population of each state. The Medicaid expansion primarily targets low-income citizens.[3] The 2013 census for "Health Insurance Coverage in the United States" indicates most uninsured Americans fall under 100% of the federal poverty level.[51] Thus, the percentage of uninsured citizens in each state serves as an appropriate measure for the potential impact of expanding coverage under Medicaid. Given each assumption, the aforementioned measure serves as a solid indication of what governors and legislatures may consider when deciding whether to opt into the expansion. KFF thoroughly tracks rates of uninsured populations, according to information from the United States Census Bureau. Thus, KFF possesses valid and reliable information pertaining to rates of uninsured populations. Considering states vary in population size, percentages are used to emphasize relativity. Table 1 portrays data for the 50 states and the District of Columbia.

Tables 1 and 2 also include data indicating whether particular states were party to *Sebelius,* for comparative purposes.[52]

***Study Sample***

This study sample excludes states that developed alternative plans through section 1115 waivers to expand coverage (Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire).[39-40, 48] Table 1. States embracing some form of expanded coverage implicates more of an attention to policy than political resilience. However, political resilience may also account for the push for alternative plans. Thus, excluding such states reduces error and increase validity and reliability of results.

The study sample also excludes split-party states that did not embrace PPACA under executive orders (New Jersey, Pennsylvania, and Rhode Island) or chose not to

expand coverage (Maine, Missouri, and Virginia), considering the impossibility to decipher party influence.[39, 49] Table 1. In those split-party states, it is unclear whether decisions were primarily driven by a particular party's influence. For the purposes of this study, party influence is essential to assess a potential relationship between political motives and executive or legislative decision-making in states.

***Analysis and Instrumentation***

This study utilizes analysis of variance (ANOVA), chi-squared testing, and hypothesis testing between statistics to reveal potential relationships between variables. (1) Between the "Opted In" and "Uninsured" variables, this study: (a) employs an ANOVA test to assess whether variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand Medicaid; and (b) employs a 2-sample t-test under the assumption of unequal variances. (2) Between the "Opted In" and "Party" variables, this study: (a) employs chi-squared testing; and (b) employs a 2-sample z-test, considering proportions reflect party affiliation between states that opted into the expansion and those that chose not to expand Medicaid. (3) Between the "Party" and "Uninsured" variables, this study: (a) employs an ANOVA test to assess whether variance exists in uninsured rates among states that classify as either Democratic, Republican, or other (independent or no-value states) according to tables 1 and 2; and (b) employs a 2-sample t-test under the assumption of unequal variances. Microsoft® Excel® Version 14.5.2 for Mac 2011 was utilized to conduct necessary tests.

***Hypotheses***

1. For the "Opted In" and "Uninsured" variables: it is hypothesized that analysis will reveal a statistically significant difference between the two variables. Under the ANOVA test, it is hypothesized that variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand Medicaid. In other words, this study expects to find a p-value small enough to allow rejection of the null hypothesis that no variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand Medicaid ($H_O: \mu_1 = \mu_2 = \mu_3$). This study also employs a 2-sample t-test under the assumption of unequal variances. Under the 2-sample t-test, this study expects to find a p-value small enough to allow rejection of the null hypothesis that there is no difference between states that opted to expand coverage and those that did not, based on potential impact on the uninsured ($H_O - H_A = 0$). Thus, it is predicted there is a relationship between policy and executive and legislative decision-making.

2. For the "Opted In" and "Party" variables: it is hypothesized that analysis will reveal a statistically significant difference between the two variables. This study employs chi-squared testing to assess how well the data align with expected results and whether the data are independent or related. The chi-squared test assesses the proportions of Democratic, Republican, and split-party states that either opted in or out of the expansion, or developed an alternative plan to expand coverage. It is hypothesized that political party affiliation and decisions regarding Medicaid expansion are related. In other words, this study expects to find a p-value small enough to allow rejection of the null hypothesis that states' decisions whether to opt into the Medicaid expansion and party affiliation are

independent ($H_O$: "Opted In" and “Party” are independent). This study also employs a 2-sample z-test, considering proportions reflect party affiliation between states that opted into the expansion and those that chose not to expand Medicaid. Under the 2-sample z-test, this study expects to find a p-value small enough to allow rejection of the null hypothesis that there is no difference between the proportion of states that opted to expand coverage and the proportion of those that did not, based on party affiliation ($P_1 - P_2 \leq 0$). Thus, it is predicted there is a relationship between politics and executive and legislative decision-making.

3. For the “Party” and “Uninsured” variables: it is hypothesized that analysis will reveal a statistically significant difference between the two variables. Under the ANOVA test, it is hypothesized that variance exists in uninsured rates among states that classify as either Democratic, Republican, or other (independent or no-value states) according to tables 1 and 2. In other words, this study expects to find a p-value small enough to allow rejection of the null hypothesis that no variance exists in uninsured rates among states that classify as either Democratic, Republican, or other ($H_O: \mu_1 = \mu_2 = \mu_3$). This study also employs a 2-sample t-test under the assumption of unequal variances. Under the 2-sample t-test, this study expects to find a p-value small enough to allow rejection of the null hypothesis that there is no difference in uninsured rates between states that differ with respect to party affiliation ($H_O - H_A = 0$). Thus, it is predicted Democratic and Republican states likely have different rates of uninsured citizens.

An array of descriptive statistics fully captures the essence of the data; including, ranges, minimums and maximums, and sample means ($\bar{x}$) ± standard deviations (s), among others. The following results reflect comparative and statistical data analysis.

# Results

## DATA PRIOR TO EXCLUSION

Prior to exclusion, this study gathered data from the 50 states and the District of Columbia. Of the 51 subjects, 32 (63%) opted into expanding coverage under PPACA or through an alternative plan, and 19 (37%) chose not to expand Medicaid. The mean percentage of uninsured citizens among all 51 subjects was 12.22 ± 3.65 and ranged from 4% (Massachusetts (D)) to 20% (Nevada (R) and Texas (R)). Additionally, 16 subjects (31%) affiliated with the Democratic Party compared to 24 (47%) that affiliated with the Republican Party. Table 1.

Of the 51 subjects in the study, 26 (51%) were party to *Sebelius.* Among the 26 that were party to *Sebelius*, 14 (54%) chose not to expand Medicaid. The mean percentage of uninsured citizens for subjects that were party to *Sebelius* was 13.38 ± 3.54, and ranged from 9% (Iowa (split), South Dakota (R), and Wisconsin (R)) to 20% (Nevada (R) and Texas (R)). Moreover, 20 of the 26 subjects (77%) affiliated with the Republican Party. Table 1.

### *Hypotheses*

1. For the "Opted In" and "Uninsured" variables: it was hypothesized that analysis would find a statistically significant difference between the two variables. Under the ANOVA test, it was hypothesized that variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand Medicaid. In other words, this study expected to find a p-value small enough to allow rejection of the null hypothesis that no variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand

Medicaid ($H_O: \mu_1 = \mu_2 = \mu_3$). The 26 subjects that opted into the expansion have a mean percentage of uninsured citizens of 11.35 ± 3.90, ranging from 4% (Massachusetts (D)) to 20% (Nevada (R)). The mean percentage of uninsured citizens for the 6 subjects that developed an alternative plan to expand coverage was 12.17 ± 2.40 and ranged from 9% (Iowa (split)) to 15% (Arkansas (split) and Montana (split)). The 19 subjects that chose not to expand Medicaid have a mean percentage of uninsured citizens of 13.42 ± 3.36, ranging from 9% (South Dakota (R) and Wisconsin (R)) to 20% (Texas (R)). Consistent with the initial hypothesis, a cursory review of the data suggest variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand Medicaid. However, an ANOVA test yielded a p-value of 0.16730 which is too high to allow rejection of the null hypothesis. Thus, this study fails to reject the null hypothesis that no variance exists in uninsured rates among states that either opted into the expansion, developed an alternative plan, or chose not to expand Medicaid ($H_O: \mu_1 = \mu_2 = \mu_3$).

2. For the "Opted In" and "Party" variables: it was hypothesized that analysis would find a statistically significant difference between the two variables. For all subjects prior to exclusion, this study employed chi-squared testing to assess how well the data align with expected results and whether the data are independent or related. The chi-squared test assessed the proportions of Democratic, Republican, and split-party states that either opted in or out of the expansion, or developed an alternative plan to expand coverage. Results are shown below:

| | Democratic | Republican | Split | Total |
|---|---|---|---|---|
| **Opted-In** | 15 | 4 | 7 | 26 |
| **Opted-Out** | 0 | 16 | 3 | 19 |
| **Alternative** | 0 | 2 | 4 | 6 |
| **Total** | 15 | 22 | 14 | 51 |
| Chi-Squared Statistic: 30.9348 | | | | |
| P-Value: < 0.00001 | | | | |

It was hypothesized that the chi-squared test would find that the variables are related. In other words, this study expected to find a p-value small enough to allow rejection of the null hypothesis that states' decisions whether to opt into the Medicaid expansion and party affiliation are independent ($H_O$: "Opted In" and "Party" are independent). The chi-squared test yielded a p-value of < 0.00001. This p-value is low enough to allow rejection of the null hypothesis that states' decisions whether to opt into the Medicaid expansion and party affiliation are independent ($H_A$: "Opted In" and "Party" are not independent). Therefore, states' decisions and party affiliation, i.e. politics, are likely related.

3. For the "Party" and "Uninsured" variables: it was hypothesized that analysis would find a statistically significant difference between the two variables. Under the ANOVA test, it was hypothesized that variance exists in uninsured rates among states that classify as either Democratic, Republican, or other (independent or no-value states) according to tables 1 and 2. In other words, this study expected to find a p-value small enough to allow rejection of the null hypothesis that no variance exists in uninsured rates

among states that classify as either Democratic, Republican, or other ($H_O$: $\mu_1 = \mu_2 = \mu_3$). The 16 subjects that classified as Democratic have a mean percentage of uninsured citizens of 9.75 ± 3.17, ranging from 4% (Massachusetts (D)) to 15% (California (D)). The mean percentage of uninsured citizens for the 24 subjects that classified as Republican was 14.08 ± 3.37 and ranged from 9% (South Dakota (R) and Wisconsin (R)) to 20% (Nevada (R) and Texas (R)). The 11 subjects that classified as other (independent or no-value states) have a mean percentage of uninsured citizens of 11.73 ± 2.49, ranging from 9% (Iowa and Rhode Island) to 16% (Alaska). Consistent with the initial hypothesis, a cursory review of the data suggest variance exists in uninsured rates among states that classified as either Democratic, Republican, or other (independent or no-value states) according to tables 1 and 2. An ANOVA test yielded a p-value of 0.00040. This low p-value allows rejection of the null hypothesis that no variance exists in uninsured rates among states that classify as either Democratic, Republican, or other ($H_A$: $\mu_1 \neq \mu_2 \neq \mu_3$).

**DATA FOLLOWING EXCLUSION**

Following exclusion of states for reasons described in the methodology, the study sample consisted of 37 states and the District of Columbia (N = 38). Of the 38 subjects, 22 (58%) have opted into expanding coverage under PPACA, and 16 (42%) have chosen not to expand Medicaid. The mean percentage of uninsured citizens in the total sample was 12.39 ± 4.00 and ranged from 4% (Massachusetts (D)) to 20% (Nevada (R) and Texas (R)). Additionally, 16 subjects (42%) affiliated with the Democratic Party compared to 22 (58%) that affiliated with the Republican Party. Table 2.

Of the 38 subjects in the sample, 20 (53%) were party to *Sebelius.* Among the 20 that were party to *Sebelius*, 13 (65%) chose not to expand Medicaid. The mean percentage of uninsured citizens for subjects that were party to *Sebelius* was 14.00 ± 3.63, and ranged from 9% (South Dakota (R) and Wisconsin (R)) to 20% (Nevada (R) and Texas (R)). Moreover, 18 of the 20 subjects (90%) affiliated with the Republican Party. Table 2.

***Hypotheses***

1. For the "Opted In" and "Uninsured" variables: it was hypothesized that analysis would find a statistically significant difference between the two variables. In other words, this study expected to find a p-value small enough to allow rejection of the null hypothesis that there is no difference between states that opted to expand coverage and those that did not, based on potential impact on the uninsured ($H_O - H_A = 0$). Thus, it was predicted there is a relationship between policy and executive and legislative decision-making. The 22 subjects that opted into the expansion have a mean percentage of uninsured citizens of 11.27 ± 4.08, ranging from 4% (Massachusetts (D)) to 20% (Nevada (R)). The mean percentage of uninsured citizens for the 16 subjects that chose not to expand Medicaid was 13.94 ± 3.42 and ranged from 9% (South Dakota (R) and Wisconsin (R)) to 20% (Texas (R)). Consistent with the initial hypothesis, the data suggest a difference between states that opted to expand coverage and those that did not, based on potential impact on the uninsured. However, data also suggest that states with higher rates of uninsured citizens did not expand coverage. This possible conclusion is inconsistent with the policy rationale of expanding coverage—to assist uninsured citizens in obtaining health insurance. Nonetheless, a 2-sample t-test under the assumption of

unequal variances yielded a p-value of 0.03562. This low p-value allows rejection of the null hypothesis that there is no difference between states that opted to expand coverage and those that did not, based on potential impact on the uninsured ($H_O - H_A = 0$). Thus, there is a relationship between policy and executive and legislative decision-making on the issue at hand, even though the direction of influence is inconsistent with the policy rationale of expanding coverage eligibility to address the massive uninsured population ($H_O - H_A \neq 0$).

2. For the "Opted In" and "Party" variables: it was hypothesized that analysis would find a statistically significant difference between the two variables. Under a 2-sample, 1-tailed z-test, this study expected to find a p-value small enough to allow rejection of the null hypothesis that there is no difference between the proportion of states that opted to expand coverage and the proportion of those that did not, based on party affiliation ($P_1 - P_2 \leq 0$). Thus, it was predicted there is a relationship between politics and executive and legislative decision-making. Of the 22 subjects that chose to embrace PPACA, 16 affiliated with the Democratic Party (73%) and 6 affiliated with the Republican Party (27%). All 16 subjects that chose not to embrace PPACA affiliated with the Republican Party (100%). Thus, a proportion of 0.73 ± 0.46 subjects opted into the expansion and affiliated with the Democratic Party, compared to a proportion of 0.00 ± 0.00 subjects that chose not to expand Medicaid and affiliated with the Democratic Party. It appears a difference exists between subjects that opted to expand coverage and those that did not, based on party affiliation. A 2-sample, 1-tailed z-test yielded a p-value of 0.00968. This low p-value allows rejection of the null hypothesis that there is no difference between the

proportion of states that opted to expand coverage and the proportion of those that did not, based on party affiliation ($P_1 - P_2 \leq 0$). Thus, there is a relationship between politics and executive and legislative decision-making ($P_1 - P_2 > 0$).

3. For the "Party" and "Uninsured" variables: it was hypothesized that analysis would find a statistically significant difference between the two variables. In other words, this study expected to find a p-value small enough to allow rejection of the null hypothesis that there is no difference in uninsured rates between states that differ with respect to party affiliation ($H_O - H_A = 0$). Thus, it was predicted Democratic and Republican states likely have different rates of uninsured citizens. The 16 subjects in the sample that affiliated with the Democratic Party have a mean percentage of uninsured citizens of 9.75 ± 3.17 that ranged from 4% (Massachusetts) to 15% (California). The 22 subjects that affiliated with the Republican Party have a mean percentage of 14.32 ± 3.43, ranging from 9% (South Dakota and Wisconsin) to 20% (Nevada and Texas). Consistent with the initial hypothesis, the data suggest a difference in uninsured rates between states that differ with respect to party affiliation. A 2-sample t-test under the assumption of unequal variances yielded a p-value of 0.00017. This low p-value allows rejection of the null hypothesis that there is no difference in uninsured rates between states that differ with respect to party affiliation ($H_O - H_A = 0$). Thus, Democratic and Republican states have statistically different rates of uninsured citizens ($H_O - H_A \neq 0$). Specifically, Republican states have higher rates of uninsured citizens than Democratic states.

In summary, comparative and statistical data analysis suggests there is a relationship between both policy and politics, and executive and legislative decision-making. The direction of influence of policy implications regarding the uninsured is

inconsistent with PPACA's policy rationale of expanding coverage eligibility under Medicaid to address the massive uninsured population. However, Republican states have higher rates of uninsured citizens than Democratic states. Therefore, inconsistencies may be incidental to overall political influence and social structure within states.

## Discussion

At a broad level, considering this study's limitations, one implication of this study's findings is that states do not adequately consider public health policy when making executive or legislative decisions.

Prior to the major insurance provisions of PPACA, the United States healthcare system was characterized by poor performance and quality. Additionally, America spent more on health care than any other country in the world. In other words, America invested a lot of resources only to not get results. A vast population of Americans did not have health care coverage. As a result, many Americans did not have access to health care—a promotor of health outcomes. To address these issues, the Obama Administration developed the Patient Protection and Affordable Care Act (PPACA).

PPACA focuses on primary care and preventive efforts, effectively incentivizes obtaining health insurance, and extends coverage eligibility to millions of Americans. Extending coverage may allow millions of Americans to access health care. Access to care may, in turn, promote health.

PPACA is a product of public health policy—characterized by a focus on preventive and upstream action to address the health of the population. The public health policy of PPACA serves as a foundation to improve the health status of the population and achieve the goals of PPACA. However, if public health policy achieves its goals, the nation will not notice it according to the paradox of prevention. Nonetheless, efforts ensue considering public health advocates believe that health is a human right. PPACA allows millions of Americans to have coverage and, in turn, access to health care. Under PPACA, millions of Americans may see better health outcomes. In summary, PPACA

comports with public health policy and aims to improve the health status of the population.

Despite compelling public health policy reasons to embrace PPACA, many states and private sector organizations opposed PPACA and sought to strike down its key provisions. With respect to the Medicaid expansion provision, opponents partially succeeded in a favorable Supreme Court decision in *Sebelius* which gave states the choice whether to opt into the Medicaid expansion outlined in PPACA, develop an alternative plan—subject to federal approval—to expand health insurance coverage under Medicaid, or do neither. Politics likely guided states in making their decisions.

In the world of politics, party affiliation and economics likely play the greatest roles. Most opposition to legislation comes from parties that did not develop it. This suggests that parties will resist enactments by their opponent parties. Despite policy rationales, political motives may guide executive and legislative decision-making.

America's bipartisan system of government creates a divide and introduces barriers to achieving the policy goals of legislation. For example, in 2013, Texas had the highest rate of uninsured citizens in the nation and, therefore, had an opportunity to make a significant impact on reducing the uninsured population. Table 1. However, Texas fought PPACA more adamantly than most other states. Texas closely affiliates with the Republican Party. Thus, while Texas could have made a tremendous impact in advancing PPACA's policy goal of expanding coverage eligibility to address the massive uninsured population, it chose not to. It is possible that economics, fiscal concerns, and per capita spending, among other factors, played a role in its decision. Politics is another explanation.

Texas is not alone. According to the results of this study, the states that chose not to expand Medicaid affiliated only with the Republican Party. Moreover, all states that affiliated with the Democratic Party embraced PPACA. Table 2. A cursory review of the data clearly depicts this divide. Moreover, a divide exists between states that opted to expand coverage and those that did not, based on potential impact on the uninsured. Statistical analysis suggests there is a relationship between policy and executive and legislative decision-making. However, the results also reveal that the states—like Texas—that had the highest rates of uninsured citizens were the states that chose not to expand Medicaid. This finding is inconsistent with the policy rationale of expanding Medicaid to assist uninsured populations. If a state has a large uninsured population, embracing the expansion could significantly advance the policy goals of PPACA. However, the states that had the greatest opportunity to advance PPACA's policy goals were the states that chose not to expand Medicaid.

Statistical analysis of states' decisions regarding Medicaid expansion and political party affiliation also found significant results. Results suggests decisions and party affiliation are likely related. Thus, there is a relationship between politics and executive and legislative decision-making.

Republican states, generally, chose not to expand Medicaid whereas Democratic states predominately embraced the expansion. In America's bipartisan system of government with conflicting interests, it makes sense politically for Democratic states to embrace PPACA and Republican states to oppose it since a Democratic administration enacted PPACA. Nonetheless, states that need expanded coverage the most, the states

with the highest rates of uninsured citizens—Republican states, as the results found—did not embrace PPACA.

This study's findings pertaining to policy and decisions regarding Medicaid expansion are inconsistent with PPACA's policy rationale of expanding coverage eligibility to address the massive uninsured population. At a broad level, considering this study's limitations, it is inferable that states did not adequately consider the public health policy underlying PPACA when deciding whether to expand Medicaid. Other factors possibly influenced the states' decisions. Nonetheless, the literature review and results suggest that political party affiliation is a viable and likely explanation.

Economics may help explain decisions regarding Medicaid expansion under PPACA. A state may consider how Medicaid expansion will affect its budget in coming years. States may assess whether they have the fiscal capacity to absorb Medicaid costs when federal funding diminishes and places more of a financial responsibility on states. States may choose to invest more per capita on programs other than Medicaid and, therefore, choose not to expand Medicaid due to spending concerns. Future studies can look more thoroughly at the numbers behind the decisions, including: budget shortages, cost sharing ratios, fiscal capacities, and per capita spending, among others. This study merely discusses economics conceptually. However, the significant results with respect to political party affiliation suggest that politics guide the executive and legislative decision-making process.

In politics, "the future is tomorrow." This mantra contrasts with the long-term nature of public health goals. Thus, a tension exists between politicians and public health advocates when deciding whether to embrace legislation that has both short- and long-

term effects. Politicians and voters alike must understand both the short- and long-term effects of legislation. Maybe then, more people will understand the need to promote health and how public health coverage can achieve that goal. This analysis is intended as a bridge between public health and law regarding policy and politics. Principles identified and discussed in this paper may prove useful when analyzing future legislation. Ultimately, this analysis identifies a need for more effective public health advocacy in order to overcome political barriers to achieving the policy goals of legislation.

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## Ross Christian Stanton

Mr. Stanton earned his Bachelor of Science degree in Biology and Minor in Psychology from the University of Kentucky in 2013. Currently, he pursues a Master of Public Health degree with a concentration in Population Health Management and Policy from the University of Kentucky College of Public Health, as well as a Juris Doctor degree from the University of Kentucky College of Law. While pursing his Master of Public Health degree, he had the opportunity to work as an intern at Supplies Over Seas—a medical supplies recovery organization in Louisville, Kentucky—under the guidance of Ms. Melissa Mershon, President & CEO. While at Supplies Over Seas, Mr. Stanton played an integral role assisting in organizational evaluation and developing a strategic plan. He also had the opportunity to work as an intern at Norton Healthcare under the guidance of Allen Montgomery, Project Executive. While at Norton, Mr. Stanton helped to develop the Kentucky Health Collaborative—a state-wide collaborative of leading healthcare providers that strives to improve clinical care, reduce associated costs, and improve the health of the population. He serves as an active member of numerous associations affiliated with the University of Kentucky, including: the Student Public Health Association, the Student Bar Association, and the Alumni Association. He proudly supports DanceBlue and the Kids Cancer Alliance. Please contact Mr. Stanton for additional information.

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# Table 1: Data for the 50 States and the District of Columbia

| State | Opted In (0 = no, 1 = yes) | Party (0 = R, 1 = D) | Uninsured (%) | Executive/Legislative* | Year of Decision | Brought Suit in *Sebelius* (0 = no, 1 = yes) |
|---|---|---|---|---|---|---|
| Alabama | 0 | 0 | 16 | N/A | N/A | 1 |
| Alaska | 1 | N/A* | 16 | Exec | 2015 | 1 |
| Arizona | 1 | 0 | 19 | Exec/Legis | 2013 | 1 |
| Arkansas | 1 | | 15 | Exec/Legis | 2014 | 0 |
| California | 1 | 1 | 15 | Exec/Legis | 2013 | 0 |
| Colorado | 1 | 1 | 13 | Exec | 2013 | 1 |
| Connecticut | 1 | 1 | 9 | Exec | 2010 | 0 |
| Delaware | 1 | 1 | 7 | Exec | 2013 | 0 |
| Florida | 0 | 0 | 19 | N/A | N/A | 1 |
| Georgia | 0 | 0 | 16 | N/A | N/A | 1 |
| Hawaii | 1 | 1 | 5 | Exec | 2012 | 0 |
| Idaho | 0 | 0 | 14 | N/A | N/A | 1 |
| Illinois | 1 | 1 | 11 | Exec | 2013 | 0 |
| Indiana | 1 | 0 | 12 | Exec/Legis | 2014 | 1 |
| Iowa | 1 | | 9 | Exec/Legis | 2013 | 1 |
| Kansas | 0 | 0 | 10 | N/A | N/A | 1 |
| Kentucky | 1 | 1 | 13 | Exec | 2013 | 0 |
| Louisiana | 1 | 0 | 12 | Exec | 2016 | 1 |
| Maine | 0 | | 10 | N/A | N/A | 1 |
| Maryland | 1 | 1 | 10 | Exec/Legis | 2013 | 0 |
| Massachusetts | 1 | 1 | 4 | Exec/Legis | 2013 | 0 |
| Michigan | 1 | 0 | 11 | Exec/Legis | 2013 | 1 |
| Minnesota | 1 | 1 | 7 | Exec/Legis | 2013 | 0 |
| Mississippi | 0 | 0 | 14 | N/A | N/A | 1 |
| Missouri | 0 | | 11 | N/A | N/A | 0 |
| Montana | 1 | | 15 | Exec/Legis | 2015 | 0 |
| Nebraska* | 0 | 0 | 10 | N/A | N/A | 1 |
| Nevada | 1 | 0 | 20 | Exec | 2012 | 1 |
| New Hampshire | 1 | | 11 | Exec/Legis | 2014 | 0 |
| New Jersey | 1 | | 12 | Exec/Legis | 2013 | 0 |
| New Mexico | 1 | 0 | 16 | Exec | 2013 | 0 |
| New York | 1 | 1 | 9 | Exec | 2012 | 0 |
| North Carolina | 0 | 0 | 16 | N/A | N/A | 0 |
| North Dakota | 1 | 0 | 12 | Exec/Legis | 2013 | 1 |
| Ohio | 1 | 0 | 13 | Exec/Legis | 2013 | 1 |
| Oklahoma | 0 | 0 | 14 | N/A | N/A | 0 |
| Oregon | 1 | 1 | 13 | Exec/Legis | 2013 | 0 |
| Pennsylvania | 1 | | 10 | Exec/Legis | 2015 | 1 |
| Rhode Island | 1 | | 9 | Exec/Legis | 2013 | 0 |
| South Carolina | 0 | 0 | 15 | N/A | N/A | 1 |
| South Dakota | 0 | 0 | 9 | N/A | N/A | 1 |
| Tennessee | 0 | 0 | 13 | N/A | N/A | 0 |
| Texas | 0 | 0 | 20 | N/A | N/A | 1 |
| Utah | 0 | 0 | 11 | N/A | N/A | 1 |
| Vermont | 1 | 1 | 8 | N/A* | 2012 | 0 |
| Virginia | 0 | | 11 | N/A | N/A | 0 |
| Washington | 1 | 1 | 11 | Exec/Legis | 2013 | 1 |
| West Virginia | 1 | 1 | 13 | Exec | 2013 | 0 |
| Wisconsin | 0 | 0 | 9 | N/A | N/A | 1 |
| Wyoming | 0 | 0 | 17 | N/A | N/A | 1 |
| District of Columbia | 1 | 1 | 8 | Exec | 2010 | N/A |
| | | | | | | |
| **Party Control:** | **Key (as of 2016):** | *Independent | **For 2013** | *HCA Commissioner | | |
| Republican | Opted In = 1 | | 12.21568627 | | | |
| Split | Alternative Plan = 1 | | 3.629400642 | | | |
| Democratic | Opted Out = 0 | | | | | |
| *Unicameral | | | | | | |

# Table 2: Data for the Study Sample (N = 38)

| State | Opted In (0 = no, 1 = yes) | Party (0 = R, 1 = D) | Uninsured (%) | Executive/Legislative* | Year of Decision | Brought Suit in *Sebelius* (0 = no, 1 = yes) |
|---|---|---|---|---|---|---|
| Arizona | 1 | 0 | 19 | Exec/Legis | 2013 | 1 |
| California | 1 | 1 | 15 | Exec/Legis | 2013 | 0 |
| Colorado | 1 | 1 | 13 | Exec | 2013 | 1 |
| Connecticut | 1 | 1 | 9 | Exec | 2010 | 0 |
| Delaware | 1 | 1 | 7 | Exec | 2013 | 0 |
| Hawaii | 1 | 1 | 5 | Exec | 2012 | 0 |
| Illinois | 1 | 1 | 11 | Exec | 2013 | 0 |
| Kentucky | 1 | 1 | 13 | Exec | 2013 | 0 |
| Louisiana | 1 | 0 | 12 | Exec | 2016 | 1 |
| Maryland | 1 | 1 | 10 | Exec/Legis | 2013 | 0 |
| Massachusetts | 1 | 1 | 4 | Exec/Legis | 2013 | 0 |
| Minnesota | 1 | 1 | 7 | Exec/Legis | 2013 | 0 |
| Nevada | 1 | 0 | 20 | Exec | 2012 | 1 |
| New Mexico | 1 | 0 | 16 | Exec | 2013 | 0 |
| New York | 1 | 1 | 9 | Exec | 2012 | 0 |
| North Dakota | 1 | 0 | 12 | Exec/Legis | 2013 | 1 |
| Ohio | 1 | 0 | 13 | Exec/Legis | 2013 | 1 |
| Oregon | 1 | 1 | 13 | Exec/Legis | 2013 | 0 |
| Vermont | 1 | 1 | 8 | N/A* | 2012 | 0 |
| Washington | 1 | 1 | 11 | Exec/Legis | 2013 | 1 |
| West Virginia | 1 | 1 | 13 | Exec | 2013 | 0 |
| District of Columbia | 1 | 1 | 8 | Exec | 2010 | N/A |
| Alabama | 0 | 0 | 16 | N/A | N/A | 1 |
| Florida | 0 | 0 | 19 | N/A | N/A | 1 |
| Georgia | 0 | 0 | 16 | N/A | N/A | 1 |
| Idaho | 0 | 0 | 14 | N/A | N/A | 1 |
| Kansas | 0 | 0 | 10 | N/A | N/A | 1 |
| Mississippi | 0 | 0 | 14 | N/A | N/A | 1 |
| Nebraska* | 0 | 0 | 10 | N/A | N/A | 1 |
| North Carolina | 0 | 0 | 16 | N/A | N/A | 0 |
| Oklahoma | 0 | 0 | 14 | N/A | N/A | 0 |
| South Carolina | 0 | 0 | 15 | N/A | N/A | 1 |
| South Dakota | 0 | 0 | 9 | N/A | N/A | 1 |
| Tennessee | 0 | 0 | 13 | N/A | N/A | 0 |
| Texas | 0 | 0 | 20 | N/A | N/A | 1 |
| Utah | 0 | 0 | 11 | N/A | N/A | 1 |
| Wisconsin | 0 | 0 | 9 | N/A | N/A | 1 |
| Wyoming | 0 | 0 | 17 | N/A | N/A | 1 |
| | | | | | | |
| **Party Control:** | **Key (as of 2016):** | | **For 2013** | *HCA Commissioner | | |
| Republican | Opted In = 1 | | 12.39473684 | | | |
| Split | Alternative Plan = 1 | | 3.996887124 | | | |
| Democratic | Opted Out = 0 | | | | | |
| *Unicameral | | | | | | |

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