OVERCOMING PARTISAN OPPOSITION TO FEDERAL POLICY IMPLEMENTATION:
The Role of Interest Groups in State Fights to Expand Medicaid

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<tr>
<td>AACHC</td>
<td>Arizona Alliance for Community Health Centers</td>
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<td>ACA</td>
<td>Affordable Care Act</td>
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<td>AHCCCS</td>
<td>Arizona Health Care Cost Containment System</td>
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<td>AzHHA</td>
<td>Arizona Hospital and Healthcare Association</td>
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<td>CBO</td>
<td>Congressional Budget Office</td>
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<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>DSH</td>
<td>Disproportionate Share Hospital</td>
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<td>FPL</td>
<td>Federal Poverty Level</td>
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<td>FMAP</td>
<td>Federal Medical Assistance Percentage</td>
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<td>GA</td>
<td>General Assembly (Virginia)</td>
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<td>HAV</td>
<td>Healthcare for All Virginians Coalition</td>
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<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
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<td>MIRC</td>
<td>Medicaid Innovation and Reform Commission</td>
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<td>NCLB</td>
<td>No Child Left Behind Act</td>
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<td>NFIB</td>
<td>National Federation of Independent Business</td>
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<td>SMI</td>
<td>Serious Mental Illness</td>
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<td>SPA</td>
<td>State Plan Amendment</td>
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<td>VAHP</td>
<td>Virginia Association of Health Plans</td>
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<td>VCU</td>
<td>Virginia Commonwealth University</td>
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<td>VCV</td>
<td>Virginia Consumer Voices for Healthcare</td>
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<td>VHHA</td>
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INTRODUCTION

The current American political environment is one of the most polarized and contentious in the nation’s history (e.g. Barber and McCarty 2013; Nivola 2010). As Alan Abramowitz (2010) explains, there is no question that policy differences between Democrats and Republicans in Washington have increased over the past several decades. Conservative Democrats and liberal Republicans who once occupied key House and Senate leadership positions have largely vanished, and there are far fewer moderates in both parties. Scholars are divided on the causes of this elite and party polarization, but many argue that the increasing prevalence, influence, and polarization of policy-oriented activists has triggered party polarization, and that the growth of single issue-based interest groups has had a radicalizing effect on parties’ primaries and legislative behavior in Congress (Layman, Carsey, and Horowitz 2006; Brady and Han 2006; Saunders and Abramowitz 2004). Yet a growth in polarization has not just taken place at the elite level—many scholars identify this trend within the American public as well. Scholars studying changes in the distance between partisan subgroups find clear evidence of polarization between self-identified liberals and conservatives (DiMaggio et al. 1996; Abramowitz and Saunders 2005), as well as increasing divisions between partisans on particular issues such as abortion, gay rights, the role of religion, and matters of race and civil rights (Bafumi and Shapiro 2009).

This trend toward increasing polarization of elites and the American public is problematic for the U.S. government’s operation in multiple crucial respects. At a time when the nation faces so many major international and domestic challenges, it is more important than ever that the government is able to act efficiently and effectively to address these pressing problems. Yet the current extreme polarization has made bipartisan cooperation and compromise rare (Abramowitz 2010) and has decreased legislative productivity (Barber and Nolan 2013).
Given the frequency of legislative gridlock, federal policy success in the legislative process is a remarkable feat. However, the battle for policy change does not end when the president signs a bill into law. Those select few federal policies that do survive the legislative process often face formidable opposition during policy implementation, particularly when implementation takes place at the state level. Many federal policies (such as the 2010 Affordable Care Act and the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act (Nivola 2010)) come out of Congress with huge stigma attached and numerous infuriated enemies who are committed to ensuring the policy’s ultimate failure, especially when policies are passed largely along partisan lines. Consequently, the implementation phase often becomes an opportunity for obstruction by devoted policy opponents who intend to both prove that the policy itself is flawed and attain revenge for the passage of the policy against their will in the first place.

In order for federal policies to achieve ultimate success in these hostile environments, an important question for study is: *In the face of organized opposition to a federal program, whether from elites or the grassroots, how can state implementation proceed successfully?*

Discovering an answer to this confounding question is essential to the operation and wellbeing of multiple important political actors. First, this research will help inform and guide the actions of lawmakers and other politicians at the national, state, and local levels. These elected officials have a duty to serve the public good and represent the interests of their constituents. While their jobs often revolve around creating change through the policymaking process, it is not enough for these leaders to simply enact legislation for which they can claim credit during re-election campaigns. If these policies fail in practice to benefit constituents and achieve their intended goals, then they are nothing more than hard-fought, carefully written pieces of paper. It is therefore vital that elected officials partake in the policy process with
constant attention to facilitating smooth and effective implementation. This research will help policymakers do that in a more informed and successful manner.

This research question is also hugely important for the operation and wellbeing of a wide range of interest groups. These increasingly powerful political actors often have much at stake in policy implementation, and so paralysis at the implementation stage may significantly affect the health and even survival of groups that serve critical functions in society. Examples of groups with a strong stake in implementation of health care policy include hospitals and hospital associations, insurers, businesses and chambers of commerce, and doctors’ and nurses’ associations. This research will elucidate how (and under what conditions) interest groups can help overcome organized opposition to implementation in order to ultimately reap the benefits of policies that are favorable to their interests.

A third group that stands to benefit immensely from research on how to successfully overcome opposition to state-level federal policy implementation is the American citizenry. With or without their knowledge, Americans suffer profusely from delayed or failed policy implementation processes. Oftentimes overwhelming public support for policy implementation has no effect on the success of the process, as the opposition may be strong enough to impede implementation regardless of the public’s stance. The answer to this project’s central question will help put an end to this troubling trend and ensure that the government responds more effectively to the needs of American citizens.

Empirical research for this project is primarily conducted within the realm of health care policy. Specifically, this study investigates state fights over implementation of the Medicaid expansion provision of the Affordable Care Act (ACA). As part of the plan to ensure that all Americans have access to quality, affordable health insurance, the ACA originally mandated that
states expand their Medicaid programs to cover all individuals below 138 percent of the federal poverty level. In the 2012 case *NFIB v. Sebelius*, however, the Supreme Court held that the federal threat of withholding all Medicaid funding from states failing to expand was coercive and violated the Tenth Amendment. This ruling effectively gave states the ability to opt-out of the expansion program, and state failure to implement a Medicaid expansion has drastic consequences for political actors and citizens at all levels. In states that are not expanding, citizens who fall between the state’s current Medicaid eligibility level and the poverty line are left without access to subsidized health coverage (“Why A State’s Health Insurers Should Support Expanding Medicaid” 2012), and hospitals, insurers, businesses, and taxpayers are forced to bear the heavy financial burden of providing care to this uninsured population. Nonexpanding states themselves miss out on a major opportunity to boost state economic growth and employment—they will have rejected $42.9 billion in federal expansion funds in 2016 (Dorn, McGrath, and Holahan 2014). But even more importantly, opting out of expansion has many serious health implications for citizens who remain without health coverage. Based on data from the Oregon Health Insurance Experiment, Dickman et al. (2014) estimate that in states opting out of the expansion, many low-income women forego recommended breast and cervical cancer screening, diabetics forego medications, and all low-income adults face a greater likelihood of depression, catastrophic medical expenses, and death.

This research into overcoming opposition to federal policy implementation, however, is not just applicable to the health care policy realm alone. As will become apparent over the course of this study, the results of this research are largely generalizable to many other issues and policy fields. In fields such as environmental and education policy, policymakers are devolving implementation power and responsibility to states with increasing frequency (Sapat 2004) (for
instance, the No Child Left Behind Act granted states great autonomy in determining standards for student and teacher performance (Manna 2010)). Consequently, policies in these other fields also face significant obstacles and opposition during implementation. Increased knowledge of successful approaches to overcoming opposition to state-level policy implementation, therefore, is tremendously relevant and important to these numerous other policy realms.

This thesis will begin with a review of the existing literature on federalism and policy implementation in the face of organized opposition, and then present a research design for the empirical component of this study. Next, the thesis will include three separate background sections that inform the empirical research and results: one section on implementation of the Affordable Care Act at the national level, and two sections detailing the battles over Medicaid expansion in each of the case study states (Virginia and Arizona). Two results sections (one for each state) on primary research conducted for this study will follow, and these results will be integrated, compared, and discussed in a subsequent analysis section. The final section of this study will draw broader conclusions about this research’s implications for multiple state and national-level actors involved in federal policy implementation in states (both within and outside of the health policy realm), and identify directions for future research around this multifaceted, timely, and important topic.

LITERATURE REVIEW

A rich body of literature on federalism and policy implementation offers much insight into potential approaches to overcoming organized opposition to the Medicaid expansion. In seeking to answer the question of how state implementation can proceed successfully in the face of organized opposition to a federal program, scholars draw on research from both within and
outside of the field of health care policy. In general, the literature points to the influence of four central factors on implementation—policy design, the leadership of political actors, state-specific characteristics, and the position and power of interest groups. The sections below will review the relevant literature under each of these four “schools of thought” and explain how scholars within each approach contribute to answering this study’s research question.

**Policy Design**

*Literature Favoring State Flexibility*

Many implementation scholars have suggested that the most successful approach to overcoming organized opposition to a federal program is to design policies that provide a great deal of state flexibility in federal policy implementation. Michael Doonan (2013), one of the leading scholars in this school of thought, bases his position in favor of state flexibility in federal policy on research on past health policies. In his book *American Federalism in Practice*, Doonan explores lessons learned from two different health care policies—the State Children’s Health Insurance Program (CHIP) and the Health Insurance Portability and Accountability Act (HIPAA). According to Doonan, these policies demonstrate how the federal government must allow for state flexibility in implementation while still providing appropriate federal regulation and support. Doonan demonstrates (through his study of CHIP) how enhancing state flexibility can be beneficial in overcoming political challenge because it expedites implementation and sets a foundation and infrastructure that roots national reform. However conversely, Doonan warns against policies (such as HIPAA) that fail to achieve their fundamental goals because they are implemented with highly passive federal oversight where the federal government has too little leverage to constrain state flexibility. If the federal government is deferential to states at every turn, according to Doonan, federal reform will meet with disaster.
Further analysis of CHIP implementation in a congressional hearing demonstrates that even though CHIP was backed by more bipartisan support than the Medicaid expansion is today, it can still provide lessons on how federal and state governments can facilitate a smooth implementation process. Participants in the hearing discuss the ways in which the 1115 waiver authority was used to support state flexibility in CHIP implementation (for instance, multiple states were granted waivers to implement CHIP through the Medicaid program rather than under CHIP rules). Additionally, testimony from the Director of the Health Care Services Division of the National Academy of Sciences points to the importance of the provision of federal funding for CHIP evaluation (Implementation of the State Children’s Health Insurance Program Hearing 1999). This could be a useful tool even in more politically polarized environments, because attaining a wealth of research on the success of the Medicaid expansion in active states may encourage inactive states to participate.

With a focus on more recent implementation efforts, scholars Timothy Conlan and Paul Posner (2011) offer a nuanced perspective on the Obama administration’s intergovernmental policies, suggesting that it has relied on a hybrid model of federal policy innovation and leadership. The administration is simultaneously devoted to a more active federal role creating national programs (in fields such as economic, financial, health care, and education reform) and reliant on states for help in implementing reform, and it has consequently used money, mandates, and flexibility in new and distinctive ways. Conlan and Posner point to the Dodd-Frank Wall Street Reform and Consumer Protection Act (legislation passed in 2010 with strong intervention from the Obama administration to safeguard existing state prerogatives for consumer protection and bank regulation in addition to authorizing a more powerful federal regulatory apparatus) and Race to the Top (the administration’s competitive grant program that calls on states to institute
wide-ranging education reforms) as examples of this strategy of hybrid federal policy innovation and leadership. Conlan and Posner praise this strategy’s accomplishments in overcoming political opposition initially—they believe this allowed the administration to balance the competing demands of its own extremely high national policy ambitions with the policy priorities and values of states that were increasingly variable and at odds with the new national ambitions. However, Conlan and Posner warn that such a strategy may prove unsustainable over the long term because looming federal deficits threaten the large funds needed to incentivize state reform and greater ideological polarization at all levels of government threatens to erode the foundations of intergovernmental cooperation.

John Dinan (2014) builds on this analysis of the Obama administration’s policy approach by focusing on implementation of the ACA specifically. Dinan focuses on the bargaining power that state officials can leverage in attempting to force federal policies to accommodate state interests. In the case of the Medicaid expansion, this leverage (derived from the state ability to decline participation in the federal program) has caused the federal government to further incentivize state participation by funding the expansion at higher levels than originally anticipated, as well as by becoming more flexible in providing waivers permitting unique state delivery of Medicaid services. Dinan uses the Arkansas-style Medicaid expansion plan as an example of a time when a state governor worked with the federal government to implement a form of a federal program despite Republican opposition in the state legislature. In order to overcome Republican state legislative opposition to Medicaid expansion in its traditional form, HHS officials permitted Arkansas to use federal Medicaid funds to purchase private coverage for all newly eligible Medicaid beneficiaries.
Barry Rabe (2007) contributes to this school of thought by demonstrating the risks that the federal government undertakes when it takes a top-down approach to implementation and denies the states input or participation in decision-making. Relying on an analysis of the effects the Bush administration’s strategy for implementing environmental policy in the face of political opposition, Rabe argues that federal attempts to make policy decisions unilaterally and force state compliance in implementation is likely to provoke strong state opposition in forms that may ultimately thwart implementation efforts. Rabe explains how by, for instance, employing regulatory mandates rather than financial “carrots” to incentivize state cooperation, the Bush administration attempted to expand federal authority over the states and concentrate decision making within tight, loyal circles of the executive branch (in a manner consistent with the administrative presidency model). However, this Bush administration strategy prompted state policy innovation to circumvent federal opposition and implement environmental policy without federal support, drove states to join forces and coordinate their policies to fill federal policy voids or counter federal decisions, encouraged interest group organizations to take the bully pulpit to attack Bush proposals, and provoked numerous state legal challenges to federal policy interpretation.

*Literature Skeptical or Critical of State Flexibility*

In contrast to those who praise policy designs incorporating state flexibility, there is also a substantial group of scholars who find these policy designs problematic at the implementation stage for a variety of reasons. In one of the most well known comprehensive analyses of federal policy implementation at the local level, Jeffrey Pressman and Aaron Wildavsky (1984) explore Oakland’s implementation of the Great Society’s “drive to save the cities” program to help solve the problems of unemployment and racial unrest. The authors are critical of the tendency to
decentralize implementation in order to get things done largely because decentralization increases the number of decision-makers involved in the implementation process, which they see as leading to high levels of controversy and antagonism, time-consuming bargaining processes, and other complexities associated with joint action. While they do not necessarily endorse removing all decentralization from policy designs, they contend that the difficulties of implementation must be considered during the policymaking process (and cannot be conceived of as a process that takes place after the design of policy) in order for policies to achieve ultimate success. In attempting to better link policy design to implementation, Pressman and Wildavsky suggest that federal policymakers should consider more direct means for accomplishing their desired ends (e.g. by removing unnecessary decision or clearance points that require an act of agreement before implementation may proceed) and take greater care to create organizational machinery for executing a program (not just for launching one).

A major argument presented by proponents of state flexibility in policy design is that this flexibility helps avoid the partisan conflict that threatens to impede policy goals and implementation. Some scholars, however, dispute the notion that state flexibility helps to overcome partisan opposition at all. Colleen Grogan and Elizabeth Rigby (2008) study the contentious efforts to reauthorize CHIP, a significant partisan conflict despite the rhetoric of bipartisanship surrounding the program. The authors point out that the reauthorization effort produced party politics of an unexpected nature—both Democrats and Republicans took unconventional positions on state flexibility. With this example, Grogan and Rigby warn that while block-grants (or programs offering large amounts of state flexibility) may be the most effective way to advance policy change when both parties recognize a need but differ on the means to that end, these policies often just serve to delay or shift partisan ideological debates to
the future. Overall, this source offers an interesting perspective on the relationship between policy implementation and partisan conflict, suggesting that rather than serving to *overcome* partisan opposition, policy designs can instead *create and promote* polarizing and unconventional partisan politics of their own.

Studies of the implementation of education policy, and specifically the No Child Left Behind (NCLB) act, have yielded substantial insight into other potential problems associated with allowing too much state flexibility. Paul Manna (2010) focuses on how NCLB created a set of administrative process requirements that states needed to follow (in some way, shape, or form) to hold schools accountable rather than creating national standards for students, teachers, or schools. Manna explains how state flexibility to make important substantive decisions prompted criticism that some state system leaders were not demanding enough of their students, teachers, and schools. These states met the letter of the law but violated its spirit by using NCLB’s flexibility to lower their expectations of students and teachers. Scholars Sara Dahill-Brown and Lesley Lavery (2012) second this conception of NCLB implementation as a warning against allowing too much state flexibility in implementing federal policy. In their study (which will be discussed further in a later section on state administrative capacity) that seeks to explain the variance among states in NCLB implementation, they found that states with little political will failed to achieve one of the fundamental goals of NCLB—raising the standards for student academic success.

Environmental policy implementation is another realm that has prompted some scholars to become critical of policy devolution. Patricia McGee Crotty (1987) explores the implementation scheme called “primacy,” which offers a state the opportunity to become the primary enforcement agent for federal policies (while the federal government sets minimum
standards and retains ultimate control over the policies). Crotty uses environmental policy as a context in which to evaluate the strengths and weaknesses of this implementation scheme. While she finds that the federal government has achieved some success in using primacy in the design of environmental policy implementation, it has fallen short in certain ways. For instance, it appears to have increased the effectiveness of state lobbies in Washington, and Crotty found that some states only accepted primacy in order to gain a competitive advantage in attracting/retaining industry (which eventually forced other states to lower environmental standards in order to compete).

Scholars Jeffrey Hill and Carol Weissert (1995) identify another potential problem associated with the delegation of authority from Congress to an administrative agent (such as the states). According to Hill and Weissert, in creating a system of oversight and control, Congress can also ironically create an incentive for the agent to ignore the initial directives and wait for changes the Congress may subsequently introduce. Hill and Weissert illustrate this “irony of delegation” phenomenon with a case study of implementation of the federal Low-Level Radioactive Waste Policy Act. In attempting to successfully implement policies that delegate authority, these authors warn against creating conditions under which states can strategically use noncompliance to alter the terms of policies that they have been directed to implement.

In a third study of environmental policy, John Hoornbeek (2005) investigates the question of whether environmental problems should be addressed through preemptive federal regulatory controls or through more collaborative grant-based policy structures that rely on state discretion. The article also investigates whether states actually build programs to address priority problems in the face of relatively low levels of federal involvement, and whether state policymaking processes are still at risk of being “captured” by dominant economic interests. In
studying these questions, Hoornbeek finds that grant-based policy structures alone do not foster truly active water pollution policies across the 50 states, and there is reason for concern about undue influence from concentrated economic interests in particular instances. Overall, this article suggests that there may be value in continued or strengthened federal involvement in grant-based policies.

Leadership of Political Actors

While policy design may be an important factor mediating policy implementation, a number of sources argue that the leadership skills and efforts of individual political actors play the largest role in determining the success of state-level policy implementation. The sub-sections below will review the literature on this school of thought, focusing on two specific types of actors—presidents and state governors.

Presidential Leadership

The idea that presidential leadership is fundamental to successful policy implementation is not unique to the current time-period—scholars have applied this theory to presidents who occupied the White House long before Obama’s time. In his book *Lyndon Johnson and the Great Society*, John Andrew (1998) offers useful insight into the reasons for Lyndon Johnson’s failure to successfully implement many of his initially popular Great Society programs. Andrew suggests that many of these failures stem from leadership mistakes on Johnson’s part. By deliberately understating the costs of new programs, beginning more programs than the bureaucracy, the public, or the budget could handle at one time, and overpromising/insisting that each new endeavor represented *the* solution to complex and perplexing problems, Johnson raised the public’s expectations for his programs to unattainable levels. Andrew also argues that Johnson failed to politically mobilize his constituency in support of his programs in advance,
which came back to hurt the programs when the middle class retreated from its commitment to
helping others and political support for Great Society programs evaporated.

Flaws in the original implementation of Medicaid following the initial development of
the program in the 1960s also points to the importance of presidential leadership during
implementation and may offer hints at the strengths and shortcomings of the Medicaid expansion
found that low visibility, a lack of federal leadership or presence on the state/local level, and a
lack of a strong, united, and supportive constituency plagued early Medicaid implementation.

More recently, scholars have continued to point to the significant role of presidential
leadership during the policy implementation process. Less than a month after Obama signed the
ACA into law, Christopher Jennings (2010), former senior health care advisor to President
Clinton, published an article in the *New England Journal of Medicine* outlining his predictions
on how ACA implementation would likely proceed. In this article, Jennings argued that the
Obama administration’s actions and strategies would be the most important factor in determining
the success or failure of ACA implementation within the politically hostile environment.
Jennings points to three main areas in which the Obama administration had the power to
determine the law’s legacy. First, Jennings highlights the importance of the President’s role in
ensuring the personnel involved in the implementation effort are highly qualified, motivated,
coordinated, and empowered. He faults Obama for the fact that his administration remained
understaffed at that time, with many nominees left unconfirmed (often because Republican
senators placed “holds” on their confirmation votes). In the highly polarized political
atmosphere, Jennings warned that a lack of leadership within key agencies could have a
devastating impact on effective implementation of health care reform. Second, Jennings
emphasized the importance of the administration’s role in ensuring skilled management of the wide variety of tasks associated with implementing such a complex policy. One of the most important such tasks is the communication of the timing, process, and substance of implementation with the public, the press, and other stakeholder groups, and Jennings argues that the Obama administration could control this by creating professionally run “communications shops” in the White House and throughout the relevant departments and agencies. Finally, Jennings predicted that the relatively young administration would inevitably make mistakes during the course of the implementation process, given that it had not had the time to build the experience or form all the trusting relationships it would need within and among the departments and the White House. He argues that the handling of these problems would be the biggest test of all for the administration, since success or failure in this could mean the difference between giving ammunition to the repeal advocates and protecting the ACA’s legacy.

An article by Frank Thompson and Michael Gusmano (2014) provides additional research on presidential leadership within the context of the ACA and highlights the role of the administrative presidency in overcoming the challenges of fractious federalism (situations in which the partisan identities of actors drive their behavior and overshadow more pragmatic considerations). Thompson and Gusmano argue that the ACA’s context was one of fractious federalism because of its partisan passage in Congress, its role as the target of intense ideological attacks by congressional Republicans, and the efforts of key party elites to promote a vertical partisan coalition with regard to the ACA implementation process. The authors specifically highlight four major strategies used by the Obama administration to coax state participation in the Medicaid expansion: preserving an all-or-nothing approach to the expansion, reassuring states that it would preserve the ACA’s financial commitment, incentivizing interest groups to
pressure state policymakers to expand Medicaid, and employing waivers to persuade states to launch Medicaid expansions. While Thompson and Gusmano do not explicitly compare the effectiveness of each of these strategies, they suggest that overall these strategies heightened prospects that ACA implementation might eventually shift from a partisan ideological model to one where state policymakers more pragmatically calculate the costs and benefits of the ACA for their particular jurisdictions.

_Gubernatorial Leadership_

Another subsection of the school of thought focused on political actor leadership argues that in the face of organized opposition to federal policy, governors are uniquely positioned to control the success of implementation in states. In analyzing state influence on national policy formation and implementation, Dale Krane (1993) describes governors as holding more authority, legitimacy, and respect than any other state official. From their position as a lynchpin between national and state governments, governors possess a wealth of expertise and experience that allows their opinions to carry substantial weight with national officials and opinion leaders. According to Krane, governors possess a freedom of action and maneuver that exceeds that of any other state officer, and in “going public” with ideas, proposals, or complaints they have easy access to influential media channels such as television news and talk shows, magazine and newspaper articles, and the lecture circuit. Krane also explains that governors can have exceptionally powerful influence when united or acting through their membership in public interest groups like the National Governors’ Association. All of these gubernatorial advantages point to these individual actors as essential assets in federal policy implementation. If the federal government is able to convince individual governors of a policy’s merit, the governors
themselves may have the skills and resources necessary to overcome organized opposition to implementation.

Although she does not study the implementation phase of governors’ role in policy specifically, Sarah Phillips’ (2008) findings on the tools governors use to promote support for contentious policies also provide insight into gubernatorial leadership efficacy. In her study of gubernatorial influence in twentieth century environmental policy, Phillips finds that governors can use language to control the rhetoric surrounding policies as well as the public and interest group support for them. Her research suggests that governors achieved environmental policy success when they downplayed the language of sacrifice and combined calls for environmental responsibility with calls for “responsible” or “balanced” growth. Additionally, Phillips claims that governors exercise resourceful leadership by building interest group coalitions to support policies. This is based on her finding that governors seized upon the political flexibility of language that weaves together concepts like environmental sustainability and economic expansion to assemble postwar coalitions representing a wide range of interest groups.

Robert Crew (1998) reinforces the idea of the power of gubernatorial leadership in the face of opposition by examining personal, political, institutional, and environmental factors related to gubernatorial leadership, all of which are widely proclaimed by theorists to be important to leadership success. Although he, too, focuses largely on the policymaking phase, his analysis of the success achieved by the seventeen governors who served in the state of Florida between 1921 and 1990 offers some useful hints at gubernatorial efficacy that may apply to the implementation phase as well. Surprisingly, Crew found that contextual variables did not explain very much of the variance in gubernatorial success, and only external economic conditions—not general political conditions—affected gubernatorial success within the legislature to a small
degree. Instead, the executive himself appeared accountable for evaluations of his leadership success—experts seemed to evaluate governors on the basis of judgments about the role they thought governors should play in the political system, without taking into account the complexity of the task faced or the constraints within which governors must work. While more research is needed to clarify these results and investigate whether these findings hold true in the increasingly polarized and hostile modern political environment, Crew’s findings appear promising in their implications for gubernatorial effectiveness in the face of political opposition.

In an analysis of implementation of insurance exchanges under the ACA, Simon Haeder and David Weimer (2013) discuss the role of governors in policy implementation and the impact of organized opposition to federal policies on governors’ positions. Overall, Haeder and Weimer regard governors as playing the formative role in determining the implementation trajectory of their states. They offer multiple examples of times when a governor has been able to successfully sway his/her state in favor of implementation. For instance, Nevada Republican governor Brian Sandoval has stuck to his initial argument that developing state solutions to ACA implementation is a more effective approach than refusing to cooperate at all costs. As a result of this persistence, he has led his state to the forefront of exchange development.

However in some cases, Haeder and Weimer explain how governors struggle to operate autonomously in the face of tremendous pressure from strong, organized partisan forces that oppose implementation. For example, in states like Kansas and Oklahoma, governors initially supported the creation of state-based exchanges and accepted millions of dollars in Early Innovator Grants. But as Tea Party opposition swept through the states, vocally raising concerns about accepting federal funds or cooperating in any form with the Obama administration, as well as specifically criticizing and personally attacking governors, both governors made about-turns
in their positions and returned the Early Innovator Grants and other federal funds. Since governors have such a large influence over implementation, eroding gubernatorial support for federal policy implementation can radically alter or halt the implementation process.

In cases where governors become paralyzed in this way, Haeder and Weimer underscore the importance of obscure officials and agencies in shaping policy implementation. They argue that insurance commissioners play a lead role in designing, preparing, and planning for insurance exchanges, yet their role has not been the focus of much scholarly attention. Although a minority of insurance commissioners are elected directly, most are appointed by the governor (often with state legislative confirmation). In making this point, Haeder and Weimer not only illustrate the importance of paying attention to seemingly minor actors like insurance commissioners, but they also imply that even when governors are visibly paralyzed, they could still exert an influence over implementation through indirect actions like their personnel appointments.

Media coverage of implementation efforts in individual states has frequently emphasized gubernatorial leadership as a factor with great potential to help a state overcome partisan opposition to the ACA. For example, a 2013 Politico article by Kyle Cheney and Jason Millman (2013) credits some governors (such as Arizona’s Republican governor Jan Brewer) with making substantial individual efforts to overcome opposition and implement Medicaid expansions in their states. According to Cheney and Millman, Brewer has worked hard to blunt opposition by characterizing Medicaid expansion as the “conservative choice” for Arizona and a “restoration” (portraying it as an effort to reverse Medicaid cutbacks the state made in more challenging budget years). Brewer has also worked tirelessly to meet with and lobby state lawmakers on this issue, and has made a high-profile push to surround herself with allies—holding large rallies with health care providers and the business community to build support for the expansion. Other
media sources offer similar portraits of gubernatorial influence in fighting to expand Medicaid (see e.g. Santos 2013; Associated Press 2014). While governors’ stances on Medicaid expansion may be partially determined by their personal positions on the issue, Cheney and Millman suggest that these stances are often mediated by governors’ ambitions for higher office—those Republican governors who are considering running for president may be more concerned about taking an unpopular stance on Obamacare than those who are not. But overall, given that the fight for Medicaid expansion under the ACA is a recent and ongoing development, scholarly research has not yet fully examined these media sources’ suggestions about gubernatorial influence on implementation of state-level Medicaid expansion.

**State-Specific Characteristics**

A third school of thought posits that variations in state characteristics and history are the clearest determinants of a state’s success at federal policy implementation. Perhaps the most obvious variant among states that is perceived to affect implementation is political party control, yet some scholars in this school of thought argue that party control does not have as dominant of an effect on implementation as one might think. According to Lawrence Jacobs and Timothy Callaghan (2013), implementation of the ACA Medicaid expansion illustrates the insufficiency of the party control variable to fully explain state variation in implementation success, since multiple states with Republicans controlling all or some of the lawmaking branches are moving ahead with the expansion while some states with significant Democratic control are lagging. In order to fully understand policy implementation anomalies like this, scholars associated with this school of thought focus on the roles of three other state characteristics—state affluence, past policy trajectories, and administrative capacity. The sections below discuss the influence of each of these three variables in detail.
Although there is relatively little existent research on the impact of state affluence on policy implementation, some scholars have found that fiscal incentives tend to prod less-affluent states more than their wealthier counterparts to participate in federal programs. In their research on Medicaid enrollment in managed care, Ae-Sook Kim and Edward Jennings (2012) found that state wealth had a statistically significant impact on states’ decisions about enrollment. While Kim and Jennings hypothesize that state access to financial resources decreases motivation to control Medicaid costs, which decreases the pressure on states to adopt a risk-based capitation program, more research is needed to confirm this and clarify how state wealth and policy implementation decisions are related.

In their article, “Why States Expand Medicaid: Party, Resources, and History,” Jacobs and Callaghan (2013) evaluate the relationship between each of the three state characteristics included in this section (state affluence, past policy trajectories, and administrative capacity) and Medicaid expansion adoption. With respect to state affluence, these scholars found unexpected yet thought-provoking results. In comparing their measure of state economic circumstances (based on per capita state income) to Medicaid adoption, they found that states with high per capita income (such as Connecticut, New York, and Massachusetts) were moving ahead with Medicaid expansion implementation, while the least well-off states (Mississippi and Idaho) were not. This correlation conflicts with the presumption that economic need would drive states to adopt Medicaid’s “good deal.” However, as the work of scholars Shihyun Noh and Dale Krane (2014) illustrates, per capita income alone may not encompass all aspects of state affluence. In analyzing state choices on how to implement health insurance exchanges under the ACA, Noh and Krane study the impact of state affluence with two different variables—state per capita
personal income in 2013 and state government budget shortfall in 2013. They found that states with more affluence and with larger fiscal problems tended to implement more core exchange functions. Applying this budget shortfall variable to analyses of Medicaid expansion may allow scholars like Jacobs and Callaghan to more fully understand how state affluence affects state decisions on whether or not to expand.

Jacobs and Callaghan explain their results with the theory that states with the weakest economies may be especially sensitive to even the marginal additional costs required to receive federal funding, and may be particularly concerned about the reliability of future funding given Washington’s fiscal instability. If Jacobs and Callaghan’s hypothesis is substantiated, it could have many implications for how the federal government should approach implementation in the face of organized opposition. For instance, it could signal that the generosity of federal funding should be tailored to individual state need, and that federal subsidies need to be more reliable and substantial in less-affluent states in order to convince the states to implement federal programs. Yet given the serious lack of empirical evidence in this field, more research is needed to determine whether causal relationships exist between state affluence and policy implementation as well as to what extent state economic need matters in the face of organized political opposition to federal programs.

Past Policy Trajectories

Scholars also posit that the trajectory of past policy in a state informs how government decision makers understand and act on their policy options. A broad body of research into many fields supports the notion that new government initiatives not only extend benefits but also create or recast structures of governance and political authority (see Orren and Skowronek 2004; Pierson 1995; Skocpol 1992; Mettler and Soss 2004). Andrea Campbell (2003) extends this idea
to include the impact of established policies on the interests of individual citizens. Campbell found that with the establishment of the Social Security program, senior citizens suddenly identified themselves as a group, connected their interests with the program, became the target of organizations seeking to mobilize them, and generally became the most politically engaged cohort. More broadly, this suggests that policies may produce identities, interests, and resources that predispose states to continue along the same policy trajectory in the future.

In research specific to the Medicaid expansion, Jacobs and Callaghan compare state decisions to move toward expanding Medicaid under the ACA to the generosity of past policy decisions to widen access to Medicaid (a variable based on Medicaid expansion to pregnant women, working parents, the medically needy, and other disadvantaged groups). They found a moderate correlation between the two variables, suggesting that differing trajectories in policy generosity correspond with the pace of Medicaid expansion. This data comparison was particularly interesting with regard to a group of Republican-controlled states that were moving ahead with Medicaid expansion at the time and also had a history of pursuing policies to widen access. Jacobs and Callaghan explain how although these states (e.g. Michigan and New Jersey) were not as far along in the expansion process as Democrat-controlled states, their recent actions raise the possibility that the pull of policy history is cross-pressuring states and moderating the effects of political opposition on decisions about health reform implementation. However, the correlations demonstrated in this study do not prove causation between the two variables, and therefore additional research is necessary to investigate these theories.

**State Administrative Capacity**

State administrative capacity is a third factor that may moderate the impact of partisan control and/or opposition on state implementation of federal policy. Multiple scholars have
documented how policies that create administrative capacity can boost the confidence of policy makers and politically powerful allies, as well as equip government with the tools to design, adopt, and implement effective programs. For instance, Paul Pierson (2000) explores the concepts of path dependence and increasing returns in politics and finds that as social actors make commitments based on existing institutions and policies, their cost of exit from established arrangements generally rises dramatically. In other words, particular courses of action, once introduced, may be almost impossible to reverse and policies that create administrative or institutional capacity promote resilient and expanding development along the same path (see also Skocpol 1992; Skocpol and Ikenberry 1983).

In researching potential theoretical frameworks for implementation, Dahill-Brown and Lavery (2012) find that institutional or state-level capacity and political will are two variables that can explain a significant amount of the variance among states in implementation of NCLB. The authors analyze the character and variance of state implementation with the variable of test rigor, and find that measures of both state capacity and political will are strongly and significantly associated with the size of the proficiency gap between the National Assessment of Educational Progress (NAEP) test and state assessments.

Research specific to health policy also supports the notion of administrative capacity as a key determinant of implementation success. In a study of five state experiences with Medicaid managed care enrollment, Marsha Gold, Michael Sparer, and Karyen Chu (1996) found that states with more effective procedures and resources to enroll Medicaid recipients in managed care (specifically, Oregon and Massachusetts) produced better results at implementation than states with weaker administrative capacity.
In studying the ACA Medicaid expansion, Jacobs and Callaghan (2013) constructed a measure of state resources and procedures related to the ACA’s new provisions—a relative measure of the variations across states in established organizational capacity. They found a moderate association of Medicaid adoption and state administrative capacity—states like New York and California with relatively strong administrative structures were further along in implementing reform than states with weaker administrative capacity such as Alabama. Jacobs and Callaghan note that Democratic states generally possess greater administrative muscle than Republican states (potentially because blue states tending toward greater government activism build better “administrative tool kits”), but of particular interest in this research are states characterized by Republican political power and strong administrative capacity such as Florida, New Mexico, New Jersey, and Michigan. It is possible that administrative capacity moderates partisanship and contributes to more reform progress than might be predicted by party control alone (Jacobs and Ario 2012). Once again, however, more research is needed in order to fully understand the role of administrative capacity and better separate its effects from those of potentially confounding variables like party control or past policy trajectory.

**Influence of Interest Groups**

Scholars like Haeder and Weimer (discussed in the political actors section) highlight the role that conservative think tanks and other oppositional interest groups have played in blocking implementation efforts. Other journalists and scholars offer additional examples of this, such as when Brad Knickerbocker explains how New Jersey Republican governor Chris Christie saw himself confronted with thinly veiled threats from the Koch brothers and Americans for Prosperity as he considered whether to implement health care exchanges in his state.
But to what extent are interest groups able to play a role in overcoming opposition to advance implementation?

Morris, Gibson, Leavitt and Jones (2014) argue that non-governmental organizations can be extremely influential in the implementation of especially those policies that shift a lot of responsibility to the state and local level. Through a case study of the Lynnhaven River NOW organization’s collaboration with the City of Virginia Beach to help address nonpoint source pollution, a problem that has evaded the reach of federal regulators since the 1972 Clean Water Act, Morris et al. argue that in policy environments where federal regulators aim to shift more responsibility to the local level, partnership between nonprofits and state and local governments can be the key to successful implementation. In the context of their case study, Morris et al. explain that the federal government (specifically, the Environmental Protection Agency) helped to foster these relationships by implementing programs (such as the Community-Based Environmental Protection program) that seek to build capacity through partnering state and non-state actors with local stakeholders. According to Morris et al., some benefits of this type of partnership between nonprofits and state/local governments include non-governmental organizations’ abilities to bring citizen volunteers with passion and energy into the implementation process, collaborate with all stakeholders to develop support for a policy’s goals, and educate the public more effectively than government can about why the policy exists and how it functions.

So if interest groups have the potential to powerfully influence implementation, how can policymakers get interest groups on their side? Suzanne Robbins (2010) investigates interest group “street-level” activity with respect to the Endangered Species Act, and focuses on how the policy arena within which groups act affects the degree of support or cooperation that interest
groups offer the implementation of any locally negotiated Habitat Conservation Plan. She explains that during policy implementation, groups attempt to secure benefits or ameliorate legislated effects by devising cooperative or conflictual strategies to influence outcomes. One of Robbins’ most important findings suggests the role of transparency and inclusiveness for generating organizational support for the plans—when organizations are included in a transparent, participatory negotiation process, they are more likely to cooperate with the implementation process. Uncertainty over outcomes is another key predictor of group cooperation and satisfaction—according to Robbins, greater uncertainty decreases cooperation because it leads groups to behave opportunistically and reflexively.

As beneficial as interest groups may be when they cooperate with policy implementation, Christina Bennett (2014) provides (through her case study of Tennessee’s Medicaid program TennCare) an important reminder that interest groups can become formidable enemies when their interests are not considered during implementation. Bennett demonstrates how when interest groups representing physicians, managed care organizations, or other stakeholder groups grew frustrated with each other and the state due to their perceived loss of influence, TennCare implementation suffered. As Bennett explains, “The relationship had deteriorated from partners in solving the health care coverage problem to suspicious opposing parties, each fighting to protect its own interests” (72). Therefore, federal and state governments must be careful not to anger interest groups and inadvertently facilitate this type of conflict in the process of attempting to overcome political opposition.

Many previously discussed sources that give more weight to the central factors of other schools of thought also mention interest groups as having an influence over policy implementation. For instance, although Haeder and Weimer (2013) largely focus on the role of
governors and other individual actors, they mention the role of interest groups in implementation of health policy and point out the irony that natural Republican constituencies (such as trade associations, business groups, and insurance companies) have been openly campaigning for state health exchanges. Additionally, Dinan (2014) mentions the pressure that hospitals put on states to approve the Medicaid expansion, suggesting that third parties (health care providers, in this case) can exert a strong influence in the implementation bargaining process.

In general, however, more research is needed before it becomes possible to fully understand the extent of interest groups’ influence over the implementation stage of the policy process. Scholars contributing to this school of thought recognize this research deficit—Morris et al. (2014) note that a scholarly analysis integrating the efforts of local grassroots environmental groups into the implementation of national water policy is largely missing, and Robbins (2010) calls the study of interest group behavior at policy implementation “a research arena ripe for systematic empirical study.”

**RESEARCH DESIGN**

The above literature review makes apparent the serious lack of research on interest group influence during policy implementation. This research gap is surprising because, as the little existing research on this topic suggests, interest groups possess powerful lobbying tools that can either serve as great assets or daunting obstacles to federal policy implementation. Nonetheless, more research is needed to ascertain how policy advocates at both the federal and state levels can incentivize the cooperation of interest groups, especially those traditionally inclined to oppose federal policies. Further research is also needed to determine what sorts of interest group organizational and lobbying strategies are most effective at overcoming political opposition to
federal policy implementation. Given these research gaps, as well as insights from preliminary research on health care policy implementation (discussed below), this study will explore the following hypothesis:

When interest group coalitions inclusive of and led by non-traditional policy allies execute well-funded and coordinated grassroots and direct lobbying campaigns, they can cause state-level implementation of federal policy to proceed effectively even in the face of strong, organized opposition.

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<th>Coalition composition</th>
<th>Lobbying strategy</th>
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<td>Inclusive of and led by non-traditional allies</td>
<td>Well-funded and coordinated grassroots and direct lobbying</td>
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Successful federal policy implementation at state level

Implementation of the Medicaid expansion provision of the Affordable Care Act (ACA) provides an interesting context in which to study this research question and hypothesis. The ACA generally devolves significant implementation responsibility to the states, and the NFIB v. Sebelius Supreme Court ruling that essentially allowed states to opt-out of expanding Medicaid only gave states greater leeway to resist ACA implementation. Additionally, ACA implementation is an excellent context for an examination of the role of interest groups during federal policy implementation, given the abundance of stakeholder groups and the widespread willingness of those groups to mobilize in support of Medicaid expansion. Impressively, many of the most powerful advocates for ACA implementation are groups that are traditionally aligned...
with conservative interests and suspicious of government policy (such as insurers and the business community).

In order to evaluate the above hypothesis, this project undertakes a comparative case study analysis of Medicaid expansion efforts in two states: Virginia and Arizona. These two states were chosen because they are well suited for the analysis of interest group coalition composition and lobbying strategy, the independent variables. Preliminary research into newspaper coverage of Medicaid expansion efforts in Virginia and Arizona suggests that interest groups strongly advocated in favor of expanding Medicaid in both states. However, news coverage of these expansion efforts suggests that interest groups in the two states pursued widely different lobbying strategies. In Virginia, preliminary newspaper research suggests that interest groups largely focused on lobbying legislators directly by investing large sums of money in professional lobbyists. While interest groups in Arizona also utilized direct lobbying, it appears that they formed a much broader and more organized coalition of interest groups than their Virginian counterparts, and were much more active in mobilizing the public to support Medicaid expansion. Since the fight to expand Medicaid was unsuccessful in Virginia but successful in Arizona, it seems that interest group strategy could account for much of the difference in implementation success.

In addition, these two cases allow the researcher to hold constant or neutralize the effect of many other potential explanatory variables. Both states currently have Republican majorities in both houses of the state legislatures. While Arizona’s legislature has been Republican-dominated for the entire period following the 2012 Supreme Court decision in *NFIB v. Sebelius*, Democrats had a very slim majority in Virginia’s senate between January and June of 2014—the period during which enactment of expansion seemed most likely. While Democratic control of
one house of the legislature would seem advantageous for a state’s prospects of expanding, Virginia was unable to implement an expansion while Arizona overcame Republican control of both houses in the legislature to do so.

Additionally, when the Supreme Court came out with its 2012 ACA decision, Republican governors led both states—Bob McDonnell was governor of Virginia and Jan Brewer was governor of Arizona. In early 2013, however, Brewer came out firmly in support of expansion while McDonnell opposed expansion of Virginia’s “broken” Medicaid program (he said it required significant reform before the state could consider an expansion). In the fall of 2013, Virginia elected a Democratic governor—Terry McAuliffe. Yet despite McAuliffe’s dedicated support of expansion and tireless advocacy efforts, Virginia failed to pass a Medicaid expansion in both the 2014 and 2015 legislative sessions. The impact of a governor’s political party (and whether his/her party is viewed as typically aligned with the federal policy) on implementation success is a variable that should be explored further in this project. However, given that both states have had governors who have committed themselves fully to lobbying for Medicaid expansion and making the issue a priority, the gubernatorial leadership variable alone does not seem to explain why Arizona has expanded but Virginia has not.

This case study selection also appears to neutralize the effect of some state-specific variables that scholars propose mediate implementation success (such as state affluence). In 2010 measures of per capita personal income by state, the U.S. Census Bureau ranked Virginia seventh and Arizona 40th (“Personal Income Per Capita in Current and Constant Dollars By State” 2012). While this difference could have various implications for state implementation success, it contradicts Jacobs and Callaghan’s (2013) finding that states with high per capita income were moving ahead with Medicaid expansion implementation, while the least well-off
states were not. From this perspective, one might expect that the more affluent state—Virginia—would be more comfortable expanding (and making the financial investment in the state’s share of expansion costs) than the less-wealthy state—Arizona. Yet this has not been the case. Given the seeming inability of these contextual variables to explain why Arizona has implemented a Medicaid expansion while Virginia has not, can interest group coalition composition and lobbying strategy provide the answer?

For the purposes of this study, policy implementation success is defined as occurring when a state institutes a program that is geared towards accomplishing a federal policy’s stated goals. It is clear that in many cases, there is a lot more to policy implementation success than just approving the institution of a federal program—even if a program is put into place it may not actually be effective in practice. However, defining success in the manner stated above is optimal for this study for multiple reasons relating to the nature of the Medicaid expansion implementation process. First, a state plan that is passed by the state legislature, signed by the governor, and approved by the federal government has already surpassed what seems to be, in most cases, the largest implementation hurdle that state Medicaid expansion programs encounter. This thesis project is focused on overcoming opposition to the implementation of federal programs, and so a state that is able to get to the point of instituting an expansion program should be viewed as successful because it has already overcome a substantial amount of the implementation opposition that it will face.

Additionally, the most significant goal of the Medicaid expansion provision in the ACA is to insure all individuals under 138 percent of the federal poverty level (FPL), and the national government has taken a hard line on this goal in deciding whether to approve state plans under its 1115 waiver authority. Although the U.S. Department of Health and Human Services (HHS)
has been lenient in using its waiver authority with regard to the details of state plans—for instance, rather than insisting on an expansion of the Medicaid program directly in all cases, it has allowed some states to use federal funding to purchase private insurance for individuals under 138 percent of the FPL—it has refused to approve plans that do not provide coverage to the entire population under 138 percent of the FPL. Therefore, even these unusual programs conform to the federal policy’s most fundamental goal, and so it is sufficient to view all approved and instituted plans as implementation successes even if in practice they may ultimately achieve varying degrees of success on some of the federal policy’s more minor goals.

This project also necessitates the definition of two independent variables included in the hypothesis—interest group coalition composition and interest group lobbying strategy. Interest group coalition composition will henceforth be defined as a variable based on the number of groups mobilized to work together in lobbying for a federal policy, the ratio of traditional and non-traditional policy allies included in this advocacy coalition, and the classification of the leadership of the coalition (whether the leaders are traditional or non-traditional policy allies). A non-traditional policy ally is an individual or group whose support for the policy is surprising or unusual. The actor’s support could be surprising for a number of reasons—perhaps the actor is typically aligned with the political party that is regarded as opposed to the policy in question, does not usually involve itself in (or take a position on) debates over policies in the given field, or was opposed to similar policies in the past. A traditional policy ally, on the other hand, is an actor whose support for the policy is much more expected (e.g. because they are aligned with the political party that commonly favors the policy or they are typically supportive of policies of the given type). The classification of policy allies as either traditional or non-traditional, therefore, is largely dependent on the background, reputation, and/or history of the policy (or policy field) at
issue. The history of the policy domain is important because it may suggest the types of groups that should be classified as expected, traditional allies. For example, since consumer organizations have been supportive of most past policies expanding access to health insurance for low-income Americans, their support for Medicaid expansion is expected and they can be classified as traditional policy allies in this case. Policy background is another important factor in ally classification—if the policy is passed through Congress largely along partisan lines, we might expect more policy allies to be members of (or frequently aligned with the interests of) the political party that widely supported the policy.

Interest group lobbying strategy, the second independent variable, will be defined as the approach that interest groups (or coalitions) take to advocating for a federal policy. This study’s hypothesis suggests that the most successful interest group lobbying strategy is one that is well funded and coordinated, and includes both grassroots and direct lobbying. Coordination, in this case, refers to the degree of organization and synchrony in the advocacy efforts of various coalition members/implementation proponents. Well-coordinated lobbying campaigns are those in which all involved groups maintain a high degree of message discipline and work as a true team to achieve a common goal. Grassroots lobbying refers to attempts to affect the opinion of the public with respect to a policy goal and encourage the public to take action to pressure legislators or government officials to support the issue at hand. Direct lobbying refers to efforts to communicate directly with legislators or government officials to attempt to influence their positions on an issue.

Data for this project comes from two main sources. First, newspaper coverage (in national, state, and local level sources) of the Medicaid expansion fights in each of these states provides background on the state and national context of Medicaid expansion battles and interest
group involvement in them, and is useful for informing the second data collection method (described in greater detail below). A comprehensive understanding of the media’s coverage of Medicaid expansion implementation (both generally and in the two states specifically) allows for more knowledgeable engagement with and questioning of expert interviewees.

The second data source for this project is semi-structured interviews with individuals involved in the Medicaid expansion fights in the two states, especially state government leaders/officials, pro-expansion interest group leaders, and pro-expansion hired lobbyists. All interviews are conducted over the phone—the geographic location of Arizona precludes in-person interviews by the author of sources in that state. In order to hold this variable constant, interviews with Virginia sources are also conducted over the phone. All interviews are recorded, transcribed, and coded by topic in order to facilitate a cross-state analysis of results.

NATIONAL ACA IMPLEMENTATION BACKGROUND

A staple of Barack Obama’s 2008 campaign for the presidency was reform of the U.S. health care system. After a long and divisive two years of negotiations and partisan battles, the Patient Protection and Affordable Care Act (PPACA), or Affordable Care Act (ACA) for short, was signed into law by President Barack Obama on March 23, 2010. Passed along strictly partisan lines, this policy has been highly stigmatized since the early days of its formation. In order to better understand how implementation of this federal program proceeded, it is necessary first to examine some of the major provisions of the law, and specifically, how the ACA reformed the health care system to extend affordable health care insurance to all Americans.

Health Coverage Expansion Under the ACA
A fundamental goal of the ACA is to ensure that all Americans have access to quality, affordable health care. In order to accomplish this goal, beginning in 2014 the law requires most individuals to maintain health insurance coverage for themselves and their dependents or pay a penalty for noncompliance. Specifically, this “individual mandate” provision requires citizens to maintain “minimum essential coverage”—a term that is defined in the ACA and its implementing regulations and applies to most forms of private and public coverage (such as employer-sponsored coverage, individual coverage, Medicaid, Medicare, etc.) (Mach 2014). The individual mandate was essential to the ACA in order to ensure that enough healthy people signed up for coverage to help pay for the sick people (Nather 2013).

Prior to the ACA, as many as 86 percent of Americans already had health insurance (Nather 2013). Most non-elderly adults either obtained this coverage through their employers or purchased private insurance plans. Americans who were enrolled in health plans before 2014 that met the requirements of the ACA were permitted to keep their plans after the implementation of the ACA. Some non-conforming plans were given a grandfathered status, which allowed individuals to keep their plan for as long as the plan stayed the same. Those previously enrolled in plans that did not meet ACA requirements or have a grandfathered status were permitted to keep their old plans without penalty until 2015 (or until 2017 in certain states) (obamacarefacts.com).

Another common source of health insurance for citizens prior to the ACA was (and still is) the various federal and state government programs designed to provide coverage to vulnerable populations. The federal health insurance program known as Medicare provides coverage to people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (medicare.gov). Medicaid and the Children’s Health Insurance
Program, both jointly run by federal and state governments, provide free or low-cost health coverage to millions of Americans, including some low-income people, families and children, pregnant women, the elderly, and people with disabilities (eligibility is determined on a state-by-state basis) (“Medicaid and CHIP Coverage” healthcare.gov). But given that health insurance could still be expensive and out of reach for lower- and moderate-income families (particularly those who do not receive health benefits from their workplace) even with these public programs, the ACA was designed to reform America’s health system in a manner that allows people of all ages and incomes to obtain health insurance in some form. The two major reforms to the system were the establishment of the health insurance marketplaces (with subsidies available to help individuals afford private insurance premiums) and the expansion of the Medicaid program to cover individuals up through 138 percent of the federal poverty level (FPL).

In order to help individuals without health coverage (or who would like to change insurance plans) compare available options and enroll in plans well-suited to their needs, the Affordable Care Act establishes health insurance marketplaces—also known as exchanges—in each state. These online marketplaces are intended to give people who do not receive health insurance through their workplace or another source easy-to-compare choices of health plans, as well as provide an easy route for low-income customers to sign up for Medicaid.

Given that the exchanges are based on the idea of competition and choice among private health insurance plans, as well as the successful trial run of the Massachusetts exchange under then-Governor Mitt Romney’s health reform law which was passed in 2006, Democrats expected Republicans to approve of and be cooperative in the implementation of this portion of the ACA. But as it turned out, many Republican leaders were politically opposed to the idea of exchanges being required under a national law (even if they agree that exchanges make practical sense in
many circumstances) (Nather 2013). As a result of this opposition, rather than creatively develop and implement exchanges on their own or in partnership with the federal government, 27 states (the majority of which are Republican-led) elected to hand the task over to the federal government entirely. In these states, consumers access their state’s Federally Facilitated Marketplaces through healthcare.gov (Kaiser Family Foundation 2015).

When shopping for health plans on exchanges in all states (regardless of whether or not the exchange is run by the federal government), individuals are able to compare four different levels of health plans: “bronze,” “silver,” “gold,” and, in some states, “platinum,” depending on the percentage of health costs individuals want the health plan to pay. The bronze plan, for example, has the cheapest premiums but covers the lowest amount of costs, so the key for consumers is to guess how much coverage they will need (Nather 2013).

Under the ACA, lower- and moderate-income families, as well as many small businesses, are eligible for financial assistance to help pay for the health insurance plans available on the exchanges. Individuals with incomes between 100 and 400 percent of the FPL qualify for premium tax credits (hhs.gov). The amount of the premium tax credit varies based upon income. The ACA also provides cost-sharing assistance to people with incomes between 100 percent and 250 percent of the FPL (The Kaiser Family Foundation 2012). According to a report released by the U.S. Department of Health and Human Services (HHS), as of February 22, 2015, nearly 11.7 million consumers selected or were automatically reenrolled in insurance coverage through the Health Insurance Marketplace. Eighty-seven percent of those who selected plans in states using HealthCare.gov (the federally-facilitated exchange) receive federal assistance to lower their monthly premiums (HHS Press Office 2015).
While the federal subsidies are designed to help millions of low-income Americans afford health coverage, individuals below 100 percent of the FPL are not eligible for these subsidies. This is because as originally enacted, the ACA required each state to expand Medicaid eligibility to nearly all low-income individuals under the age of 65 with incomes at or below 133 percent of the FPL (which would effectively become 138 percent of the FPL because Medicaid eligibility determinations would disregard 5 percent of income) (American Academy of Actuaries 2012). Under the original law, any state that refused to expand its Medicaid program would have all federal Medicaid reimbursement funds (not just those associated with the expansion) withheld (Thomas 2012). This expansion was designed to fill in historical gaps in Medicaid eligibility for adults and intended as the vehicle for providing insurance coverage to low-income individuals (Garfield et al. 2014). It marked a significant change from previous regulations, because prior to the ACA there was no baseline income level for mandatory eligibility, so many states did not provide Medicaid to childless adults and covered parents only at much lower income levels (Thomas 2012). According to CBO estimates prior to the June 2012 Supreme Court decision, 16 to 17 million people would be enrolled in Medicaid from 2016 on (“Updated Estimates for the Insurance Coverage Provisions of the ACA” 2012).

Medicaid is an entitlement program that was enacted through the Social Security Amendments of 1965. Federal and state governments jointly fund it, with federal Medicaid spending open-ended (unlike CHIP, which is a capped federal grant to states) and the program’s total spending outlays dependent on the generosity of state Medicaid programs. If states choose to participate (which all 50 states do), they must follow federal rules in order to receive federal reimbursement to offset most of their Medicaid costs. Each state designs and administers its own version of Medicaid under broad federal rules, which has resulted in widespread state variability.
in eligibility levels, covered services, and the methods by which services are reimbursed and delivered (Herz 2011). It is important to note, however, that a number of the federal requirements may be waived with approval from the Secretary of HHS (Thomas 2012). Section 1115 of the Social Security Act gives the Secretary authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs, and therefore these 1115 waivers allow states additional flexibility to test new or existing approaches to financing and delivering care (“Section 1115 Demonstrations”).

The state-specific federal share for Medicaid benefit costs (called the federal medical assistance percentage, or FMAP) is determined by a formula that establishes higher federal shares for states with per capita personal income levels lower than the national average (and vice versa for states with higher per capita income levels). The FMAP is at least 50 percent of benefit costs in all states (Herz 2011), and as of FY 2016, Mississippi’s 74.17 FMAP is the highest of any state (“Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier” 2015). However, under the ACA, the federal government has promised to pay a much larger percentage of the added costs associated with Medicaid expansion. If a state expands Medicaid, the federal government has pledged to pay 100 percent of the cost of newly eligible enrollees during calendar years 2014-2016. After that, the federal share will gradually decline to 90 percent in 2020 and subsequent years (Dorn et al. 2013).

*The Supreme Court Steps In: NFIB v. Sebelius*

On the day that President Obama signed the ACA into law—March 23, 2010—the state of Florida, joined by 25 other states, filed a lawsuit in the federal district court challenging the constitutionality of the individual mandate and the Medicaid expansion. A separate group of plaintiffs, including the National Federation of Independent Business (NFIB) and some
individuals who did not have health insurance at the time, also filed a lawsuit in Florida. The two cases were considered together by the Supreme Court (A Guide to the Supreme Court’s Affordable Care Act Decision 2012).

Thirteen states filed amicus (“friend of the court”) briefs documenting their support for the individual mandate and Medicaid expansion, the District of Columbia supported the individual mandate, and two states (Iowa and Washington) were on both sides of the case, as their governors and attorneys general took opposite positions (A Guide to the Supreme Court’s Affordable Care Act Decision 2012).

The Supreme Court agreed to decide the constitutionality of two of the major provisions in the ACA—the individual mandate and the Medicaid expansion. The decision in NFIB v. Sebelius was announced on June 28, 2012. The majority of the Court—Justices Breyer, Kagan, Ginsburg, Sotomayor, and surprisingly, Chief Justice Roberts—held that the individual mandate is a constitutional exercise of Congress’ power to levy taxes (A Guide to the Supreme Court’s Affordable Care Act Decision 2012).

Many observers feared that this case (and particularly the ruling on the individual mandate) would bring about a total dismantlement of the ACA, and so the Court’s decision to uphold the mandate was celebrated as a huge success. However, the Court’s decision on the second major issue—the constitutionality of the Medicaid expansion—was not quite as favorable to ACA supporters.

The constitutional challenge to the Medicaid expansion in this case was that, under the Spending Clause and the Tenth Amendment, states would be coerced into paying for the increased Medicaid requirements (given that states did not have adequate notice to voluntarily consent and failure to comply with the heightened Medicaid requirements might result in the
federal government withholding all Medicaid funding). The states argued that the withdrawal of this federal aid would have a dramatic effect on the ability of the states to provide health care to their populations because Medicaid represents 40 percent of all federal funds that states receive, most states receive more than $1 billion in yearly Medicaid funding, and this number was projected to increase under the ACA. Therefore, the states argued that they had no choice but to comply with the Medicaid expansion provisions (Thomas 2012).

Reversing the Eleventh Circuit decision, the Supreme Court held that the threat of withholding all Medicaid funding for failure to comply with the ACA Medicaid expansion was coercive and violated the Tenth Amendment. The Court declared that the remedy to this constitutional violation was to sever the HHS Secretary’s authority to employ this enforcement mechanism—the Court said that Congress may not make all of a state’s existing Medicaid funds contingent upon the state’s compliance with the ACA expansion (Thomas 2012). The Secretary may, however, withhold funds designated for Medicaid expansion from states choosing not to comply. In effect, the NFIB v. Sebelius ruling made state participation in the ACA Medicaid expansion voluntary.

*Post-NFIB v. Sebelius Implementation Battles in States*

The NFIB v. Sebelius ruling turned implementation of the Medicaid expansion provision of the ACA into a much more lengthy, contentious, and complicated process than originally anticipated. Given the choice of whether to participate, many states have decided to opt-out of the expansion program.

To make a change to its Medicaid program (such as adopting a Medicaid expansion) a state’s Medicaid agency must submit and receive Centers for Medicare and Medicaid Services (CMS) approval of either a state plan amendment (SPA) or a 1115 waiver request. However,
before working with federal partners, state Medicaid agencies often must work with state lawmakers (governors and/or legislatures) to obtain authorization and appropriations before implementing an expansion. State rules on the process of making these policy changes vary:

Some states allow expansion to be authorized through changes in regulation (and therefore by agencies at the direction of the governor), while others require expansion to be made through changes to state law (action that necessitates legislative approval). Of the states that have expanded, most have done so through the standard legislative process (either through a stand-alone bill or as part of budget legislation), while a few have adopted expansion through executive action. Several states that are not currently expanding have enacted laws prohibiting expansion without legislative approval. A limited number of states have expanded coverage through Section 1115 waivers, which require additional steps to obtain federal approval but are submitted after a process that is largely the same at the state level as if the state were adopting an expansion through an SPA (“An Overview of Actions…” 2015). While the federal government has granted states authority to implement the expansion in ways that go beyond the flexibility provided by the ACA (for instance, allowing some states to use federal money to enroll low-income individuals in private insurance plans rather than the Medicaid program), CMS has been firm in mandating that all expansion plans insure the entire population up through 138 percent FPL (it has not granted federal money for partial expansions).

Many governors, including some Republicans, have embraced the expansion, finding the offer of federal funds hard to refuse. As of March 2015, 28 states and the District of Columbia have expanded Medicaid. Of those 29, 23 have pursued a traditional Medicaid expansion through a SPA and six states (Arkansas, Iowa, Indiana, Michigan, New Hampshire, and Pennsylvania) have expanded through waivers. Twenty-two states have declined to expand their Medicaid
programs (“Current Status of State Medicaid Expansion Decisions” 2015). Partisan politics are to blame for much of this noncompliance—only nine states with Republican governors have accepted the federal government’s generous offer to cover expansion costs (“Republican Lawmakers Block Bids to Expand Medicaid” 2015).

As previously discussed, because the ACA envisioned Medicaid as the vehicle for providing health coverage to low-income individuals, it does not provide financial assistance to people below 100 percent of the FPL for other coverage options (e.g. private plans available through exchanges) (Garfield et al. 2014). Individuals who are ineligible for Medicaid based on a state’s decision not to carry out the ACA expansion are eligible to receive a hardship exemption from the individual mandate and its associated penalty (Mach 2014). Yet this “coverage gap” (in which millions of poor individuals and families are left without health coverage in states choosing not to expand) undermines the ACA’s goal of making quality, affordable health insurance accessible to all Americans.

In fighting for the state implementation of the expansion, the federal government and other expansion proponents have had critical support from a wide range of stakeholders and interest groups—both traditional and non-traditional allies of progressive policy. Among the most powerful of these stakeholders are health insurers, who have a clear financial interest in ensuring that as many states as possible expand their Medicaid programs. A major reason that they stand to benefit from the Medicaid expansion is that in states forgoing expansion, many more people will be “churning” back and forth between coverage (both Medicaid and private insurance) and being uninsured. These individuals are likely to concentrate their health care use during periods when they have health coverage, after forgoing preventative services and delaying or skipping needed care during periods when they lack coverage. As a result, the claims that
insurers must pay on behalf of these individuals are likely to be higher than for those who have had continuous coverage. Other challenges to insurers in states declining to expand include depressed overall enrollment in insurance programs, the loss of a significant business opportunity (especially for insurers operating Medicaid managed care plans), an unbalanced risk-pool (with the youngest and healthiest individuals—typically the cheapest population for insurers to cover—forgoing care), greater uncertainty about the characteristics of people who will newly enroll in coverage (which could cause insurers to build in a “risk premium” that would unduly raise premiums in and outside of exchanges), and disruptions in care coordination and management as people churn in and out of coverage (“Why A State’s Health Insurers Should Support Expanding Medicaid” 2012). For all of these reasons, insurers have lobbied actively for expansion in many states.

Hospital groups have become another key ally in the fight for Medicaid expansion. Many hospital associations have paid for television and newspaper ads, organized rallies, united disparate stakeholder groups, and choreographed legislative testimony in support of the Medicaid expansion (Ollove 2013). Like insurers, hospitals have a huge financial stake in state expansion decisions. When negotiating the original terms of the ACA with the federal government, hospitals agreed to a major cut in the Disproportionate Share Hospital (DSH) payments they receive from the federal government to cover the costs of providing uncompensated care to low-income and underserved individuals. Hospitals agreed to these cuts based on the assumption that Medicaid expansion would be mandatory in all states. They expected that the drastic fall in the number of uninsured and underinsured people would lower their uncompensated care costs by enough to more than make up for the DSH cuts. But while the gamble paid off in states that have expanded Medicaid (“How A State’s Choice on Medicaid Expansion Affects Hospitals” 2014),
states refusing to expand following the unforeseen Supreme Court ruling have put the financial status of their hospitals (especially charitable and safety-net hospitals) at risk (Ollove 2013). Giving hospitals a breather in light of the stall in Medicaid expansion, the federal government has delayed the start of the annual DSH cuts three separate times in the last three years (the latest delay was signed by President Obama in April 2015 and postponed the cuts to begin in fiscal year (FY) 2018) (Kardish 2015). But with the FY 2018 initial cut of $2 billion in DSH payments (Medicare Access and CHIP Reauthorization Act of 2015) still looming, Medicaid expansion lobbying efforts in resistant states are still a high priority (Kardish 2014).

Despite the efforts of expansion proponents, opposition to expansion has been fierce and seemingly insurmountable in some cases. The notion of expanding Medicaid has long been toxic to many GOP lawmakers, who would like to see the ACA “repealed and replaced” and are under tremendous pressure to avoid supporting “Obamacare” in any form. Much of this pressure comes from conservative interest groups that have done everything in their power to block expansion implementation. Tea party-affiliated groups such as Americans For Prosperity (AFP) have invested millions in states around the country to fund anti-expansion campaigns (Stolberg 2013), which often involve hiring lobbyists, pressuring lawmakers through grassroots organizing in specific districts, and campaigning or threatening to campaign against Democrat and Republican legislators who are perceived as “pro-Obamacare.”

Notwithstanding unprecedented levels of federal funding, many Republican legislators and governors argue that their states cannot afford even the small portion of expansion costs that the federal government will not cover. However, the CBO estimates that states will spend only 1.6 percent more on Medicaid and CHIP due to health reform than they would have spent without health reform, and the 1.6 figure is before counting the added savings that the Medicaid
expansion will produce in expenditures for services such as mental health and substance abuse treatment provided to the uninsured (Park 2014). Many Republicans also oppose expansion based on the concern that the federal government will eventually renege on its funding commitments, however expansion proponents say that this is true of virtually any federal program that assists states (Editorial Board 2014). Additionally, if states find this to be a serious concern, they can incorporate “circuit breakers” into their plans (provisions that end a state’s expansion program if the federal government reduces its promised funding levels) (Crawford and McMahon 2014).

The 2015 midterm elections did not help the situation—the election results did not replace any expansion-opposing governors with expansion advocates. According to a November 2014 New York Times article, “The re-election of four Republican governors means that the future of Medicaid expansion under the Affordable Care Act is unlikely to change course” (“Election Will Leave Medicaid Policies Largely Unchanged” 2014). So despite the many clear economic and social benefits of expansion, many states continue to deny basic health care coverage to large segments of their populations.

**VIRGINIA BACKGROUND**

When the Supreme Court announced its decision on *NFIB v. Sebelius* on June 28, 2012, Virginia Governor (and head of the Republican Governors Association) Bob McDonnell was far from pleased. Calling the decision to largely uphold federal health care reform “extremely disappointing for Virginia and for America,” McDonnell said that the state would evaluate steps necessary to comply with the ACA and implement the law “in the most effective and least costly and burdensome way possible” (Martz and Meola 2012).
In a July 10th letter to members of the Virginia legislature, McDonnell announced his plan of response to the Supreme Court decision—essentially, like some other conservative governors, he would stall. He would not call the General Assembly (GA) into a special session to implement a state-run health insurance exchange, and his administration would take its time evaluating whether or not to expand eligibility for Medicaid. This delay tactic seemed partially based on his lingering hope that Congress would repeal the health care law after the November 2012 election. Without naming Republican candidate Mitt Romney by name, McDonnell wrote, “One presidential candidate has said he will repeal PPACA and grant waivers to the states if he wins the November election” (Sluss 2012). A couple of days later at a National Governors Association annual meeting, McDonnell argued that spending time and money implementing a program that might be changed “drastically” a few months later did not make sense (Sonmez 2012).

Like many governors reluctant to expand, McDonnell argued that the Medicaid program was “broken” and in need of reform before his state could consider expansion (Sonmez 2012). In his June letter to lawmakers, he noted that Virginia’s Medicaid budget was already large and growing at an unsustainable rate, yet states had limited ability to control those costs because of inflexible federal rules governing Medicaid (Davis 2012). He highlighted the high cost to Virginia of expanding, even with the federal government’s coverage of a majority of the cost.

Throughout the summer and fall of 2012, McDonnell held off on making a decision about whether to opt-in to the Medicaid expansion program. Yet after President Obama’s defeat of Romney in November made it clear that the ACA would not be repealed in the near future, McDonnell came out in opposition to expansion in Virginia. In a press conference just days after the election, McDonnell stated, “I don’t believe the federal government can possibly deliver its commitment to fully fund the program, and I don’t want to be part of contributing trillions of
dollars to the national debt” (Hall 2012a). In late December, he told legislative budget committees that his new budget had no money for Medicaid expansion (Hall 2012b).

McDonnell was similarly resistant to implementing other aspects of the ACA. After appointing the Virginia Health Reform Initiative Advisory Council in 2010 to make recommendations on exchange implementation, McDonnell disregarded the Council’s unanimous recommendation that Virginia operate its own exchange, and instead left the job of administering an exchange in the state to the federal government (Hope 2012).

Supporters of the expansion did not agree with McDonnell’s analysis of the situation. They found it unacceptable that about one million people—almost one in eight Virginians—lacked health insurance, and Virginia ranked 48th among states in per capita spending for Medicaid as a result of its stingy, “restrictive eligibility standards” (Editorial Board 2014). In a July 11, 2012 letter to the governor and the VA General Assembly, Congressman Gerry Connolly said that opting out of the Medicaid expansion would prove a costly and “historic mistake” for Virginia. In urging McDonnell to seize the opportunity to make life better for all Virginians, Connelly argued that participation in the expansion would reduce the number of uninsured, create jobs, slash uncompensated care costs, help reduce premiums for all Virginians, and give the state billions of dollars in federal funds (Connolly 2012). An early January 2013 study for the Virginia Hospital and Healthcare Association supported Connelly’s stance—the study found that the estimated economic benefits from expanding Medicaid would be more than four times those from opting out—an expansion was estimated to generate nearly $4 billion a year over the next six years (from the beginning of 2013) and would produce almost 31,000 jobs (mostly in the health care industry) (Martz 2013a). Weighed against these benefits, proponents felt that worries about expansion (such as the concern that the federal government would
eventually renege on its promise to pay 90 percent of expansion costs, which expansion proponents say is true of any federal program that assists states) were unpersuasive (Editorial Board 2014). Senator Janet Howell, a Democrat representing Fairfax stated, “We must not deprive over 300,000 Virginians of health care. For years we’ve known we have one of the most miserly programs in the country. We couldn’t improve it much because we didn’t have the money. Now that money is being offered us, and we shouldn’t spurn it” (Vozzella 2013a).

Recognizing the importance of the expansion decision to the Virginia economy and their individual organizations, hospitals, consumer groups, and other pro-expansion organizations began to mobilize to advocate for expansion. The Virginia Commonwealth University (VCU) Health System and the University of Virginia (UVA) Health System, the state’s two largest teaching hospitals and providers of care to uninsured and Medicaid patients, were well aware of the severe impact that upcoming cuts to DSH payments (under the ACA) would have on their ability to provide care if the state did not expand its Medicaid program. As a result, they began an active campaign to educate the legislature about the ramifications to the state, its hospitals, and its citizens of not implementing an expansion. The Healthcare for All Virginians (HAV) coalition, a large association of interest groups that existed prior to the Supreme Court decision to work on health care coverage issues, shifted its focus and made Medicaid expansion its top priority (Hanken 2015). Before Governor McDonnell announced his position on Medicaid expansion, he and members of his cabinet had multiple conversations with various advisors and interest group leaders about expansion, yet he was “adamantly opposed to it from the get go” (Lynch 2015).

In early 2013, Medicaid expansion was a major issue of consideration as the Virginia GA worked to pass budget amendments to the previous year’s two-year spending agreement. On
February 22nd, it looked as if the Assembly had finally arrived at a deal. Senate Democrats had sought an accommodation on Medicaid as a condition for supporting the budget and a separate transportation funding bill. But a surprise written advisory opinion from Virginia Attorney General (and gubernatorial prospect) Ken Cuccinelli (that was circulated on the morning of the 23rd) raised constitutional questions about the Medicaid provision in the proposed budget. The provision called for a legislative commission to oversee pre-expansion reforms (many of which would require federal waivers to give the state more control over how it runs Medicaid), and if the commission determined that the Medicaid reform conditions were met then it could direct the state agency that administers Medicaid to expand enrollment as early as July 1, 2014 (rather than January 1, as allowed under the ACA). However, Cuccinelli wrote in his advisory opinion that Virginia’s constitution prohibits the GA from delegating final legislative authority regarding budget and other enactments to a committee composed of a subset of the members (Sluss 2013). Although budget negotiators argued that the state already empowers legislative commissions with similar conditional oversight powers, House and Senate negotiators responded to Cuccinelli’s action by revising the disputed provision to ensure that the appropriation of the funding for the potential 2014 expansion (if the committee were to determine that the required reforms were in place) would be approved by the assembly, not the committee (Martz 2013b).

In early March, Governor McDonnell sought to debunk claims that the budget proposal meant VA would be moving forward with expansion, saying in a letter to HHS Secretary Sebelius that the budget language “actually places a firewall against expansion consideration” unless the federal government agrees to a series of reforms (“McDonnell Tells Feds…” 2013). Then in late March, McDonnell proposed several amendments to the GA budget language, much of which specified the reforms that would be required before a new legislative commission
would sign off on expansion (Martz 2013c). McDonnell remained opposed to the expansion at that time, and Cuccinelli’s office claimed that the governor’s amendments did not solve the constitutional questions that Cuccinelli raised earlier in the year (Davis 2013a). On April 3rd, both houses of the Assembly approved McDonnell’s Medicaid amendments (in addition to his amendment to a health insurance reform bill to prevent health plans sold through the new exchange from covering abortion services) (“General Assembly Approves McDonnell’s Medicaid Amendments” 2013).

Later that month, the GA finalized appointments to the Virginia Medicaid Innovation and Reform Commission (MIRC) (the commission created by the legislative compromise on expansion). The four senators appointed by Republican Finance Chairman Walter Stosch had all voiced support for expansion if the state could achieve reforms to Medicaid, and Stosch (who would also serve on the commission) had taken a neutral position on expansion after playing a key role in designing the compromise budget amendments on the issue. In contrast, Republican House Speaker William Howell appointed five delegates to the commission who he said “share [his] skepticism” over expanding the program. The 12-member commission also included Secretary of Health and Human Resources William Hazel Jr. and Finance Secretary Richard Brown as non-voting members (Martz 2013d). Before expansion could go forward, the rules set up for the commission specified that three delegates and three senators must agree that reforms to the state’s Medicaid program have been achieved. The commission held its first meeting on reform progress on June 17th (Wilson 2013).

As the commission began to move forward and pro-expansion groups worked to educate legislators about the benefits of expansion, Tea Party interest groups implemented a powerful grassroots campaign to scare legislators away from even considering expanding coverage under
“Obamacare” in Virginia. One leading target of Americans for Prosperity (AFP), the conservative advocacy group backed by billionaire industrialist brothers Charles and David Koch, was MIRC chairman Emmett Hanger Jr., a Republican state senator from the deeply conservative Shenandoah Valley. An October 2013 New York Times article reported that AFP members were engaged in an active campaign to intimidate Hanger in Richmond and at his home. Angered that Hanger had expressed openness to expansion, volunteers phoned Hanger’s constituents, knocked on 2,000 doors in his rural district, attended his county’s town committee meeting, and attended MIRC hearings while dressed in green T-shirts bearing the slogan “Economic Freedom in Action!” These anti-expansion efforts were not unique to Virginia—AFP had paid staff members in 34 states and spent millions in states around the country to run similar aggressive campaigns (Stolberg 2013).

In May 2013, Virginia received federal permission to start a three-year pilot program to coordinate services for people who are “dual-eligible” for the Medicaid and Medicare programs. This program (known as Commonwealth Coordinated Care) was meant to save the state money and consolidate services to duel-eligible Virginians, and was a key step toward completing the reforms necessary before the state would agree to a Medicaid expansion (Davis 2013b).

Just as the 2013 Virginia gubernatorial election campaigns started heating up, a political scandal emerged in the state involving McDonnell (who was term-limited as governor but recognized as a possible 2016 presidential contender) and Cuccinelli (who was running to fill McDonnell’s spot in Virginia’s Executive Mansion). The story came out after Todd Schneider, the former personal chef to McDonnell and his family, told law enforcement agents that a $15,000 catering bill for the wedding of the McDonnells’ middle daughter was footed by a political donor. It was subsequently discovered that the donor, Jonnie Williams Sr., has given
over $120,000 to McDonnell’s campaigns and in return, on multiple occasions McDonnell and his wife Maureen promoted a dietary supplement called Anatabloc produced by Williams’ company Star Scientific. Cuccinelli also had ties to Williams—he had received thousands of dollars in gifts from Williams and bought stock in Star Scientific but failed to disclose his holding as required by law for almost a year. When Star Scientific sued Virginia over a tax bill in 2009, Cuccinelli resisted pressure from Democrats to recuse himself (only finally agreeing to appoint an outside counsel once this scandal came to light in spring 2013) (Gabriel 2013).

The 2013 Virginia gubernatorial race, which unfolded against a backdrop of headline-grabbing investigations regarding the gifts scandal, presented voters with clear choices on the Medicaid expansion issue. Remaining firmly opposed to expansion, Cuccinelli engaged in a tough battle with Terry McAuliffe, former Democratic National Committee Chairman who had no previous experience in state government. McAuliffe made Medicaid expansion central to his bid for governor, claiming that expansion could “create jobs, reduce costs, and provide lifesaving coverage to hundreds of thousands” (Cordell 2013). McAuliffe repeatedly promised that as governor of Virginia, he would veto any budget not including Medicaid expansion. While Republicans criticized McAuliffe for taking an autocratic, highly partisan approach to governing that would hold the budget hostage to his Medicaid goal (in contrast to his own claim of bipartisanship), the McAuliffe campaign said that he was not threatening a government shutdown, but rather just expressing the importance he placed on expansion (Vozella 2013b). McAuliffe also used the fall 2013 budget impasse in Congress as political fodder, claiming that Cuccinelli was “more concerned with appeasing his extreme Tea Party allies than protecting the economic well-being of Virginia” and would let government shut down to re-fight a health law that had been passed three years ago (Davis 2013c).
In the end, McAuliffe narrowly won the hotly contested governor’s race. As McDonnell prepared to leave office in January 2014 (while still under threat of federal indictment for the gifts scandal), Governor-elect McAuliffe reached out to every Republican in the GA, beginning the process of trying to sell them on the expansion and fulfill his campaign promise to become a bipartisan dealmaker. However initially, expansion opponents showed no signs of budging. McAuliffe also tried to reinforce his message of bipartisanship by electing to reappoint McDonnell’s health secretary (William Hazel Jr.), as well as McDonnell’s agriculture and finance secretaries (Vozzella 2014).

In his inaugural address on January 10th, McAuliffe made multiple appeals to finding “common ground” solutions to pressing issues and setting politics aside for the greater good. He also adopted the strategy of using noncontroversial mainstream arguments to push for liberal measures. By framing Medicaid expansion and equal rights for the LGBTQ community as measures necessary to attract business and create jobs (rather than as ideological causes), McAuliffe sought to make representatives opposing his initiatives appear as obstructionists. The prospects of Medicaid expansion taking place in VA appeared promising as McAuliffe’s term began, especially because the governor had powerful allies in the state’s chambers of commerce and hospitals (McCartney 2014).

In a move that seemed to undermine his efforts at bipartisanship, on January 19th McAuliffe announced that he would take the power to expand Medicaid into his own hands through a proposed budget amendment (an act that Republicans claimed he did not have the right to do) if the Medicaid Innovation and Reform Commission did not agree within the next 60 days to expand (Vozzella 2014b). In response, senior members of the House of Delegates hardened their opposition to expansion—some Republican leaders declared outright that eligibility for
Medicaid would not be expanded that year, while others called for a broad outside audit of Virginia’s Medicaid program. McAuliffe responded that he would welcome an audit, but did not feel that an ongoing audit should be used as an excuse to avoid expansion (Laris 2014).

After a special election tipped power in the Senate to the Democrats (Democrat Lynwood Lewis Jr.’s election meant that the chamber would remain evenly split 20-20, but Democrats had the tie-breaking vote with newly-elected Lieutenant Governor Ralph Northam), they used a series of parliamentary motions to give themselves majorities on most of the chamber’s 11 committees and replaced Republican chairmen with Democrats (Nolan 2014a). Senate Democrats also muscled through a change to the chamber’s rules, giving the chairman of the Senate Rules Committee the right to single-handedly kill any Senate bills that have been “substantially” altered in the House (an attempt to keep the GOP-dominated House from hijacking Senate bills) (Vozzella and Weiner 2014).

Not long after this change, Senate leaders proposed a commercial alternative to expanding the state’s Medicaid program similar to expansion alternatives approved by CMS in states like Arkansas and Iowa. Adding on to a previous bill that proposed “Marketplace Virginia” as a replacement for Virginia’s federally-run exchange, Republican Senator John Watkins suggested using federal dollars to provide insurance premium assistance to about 250,000 Virginians who were previously ineligible for Medicaid (Martz 2014a). This private option gained the support of Democrats and three Republican Senators (including Watkins) (Martz and Nolan 2014a).

Rather than sending the legislation to a sure death in the House, the Senate attached it to its version of the two-year budget. The House budget did not include any form of coverage expansion, setting up a showdown over the budget that needed to pass by July 1st to fund basic
government services. After weeks of stalemate, the GA’s 60-day session ended on March 8th with no resolution on the budget. Legislators returned to Richmond on March 24th for a special session, at which time McAuliffe proposed a new budget (still including a form of expansion) that was a complete non-starter in the House (Vozzella 2014c).

Under the state constitution the General Assembly has sole authority to appropriate money (including $2 billion a year in federal pass-through funds that would bankroll the Medicaid expansion). But when the budget standoff persisted into June, word spread that the McAuliffe administration had begun researching options for expanding Medicaid by executive order. In addition, McAuliffe claimed that he had broad authority to keep most of the state government running if the standoff were to prevent passage of the budget before the July 1st deadline (Vozzella 2014d).

But before it came to that, the situation took a dramatic turn on June 10th when Democratic Senator Phillip Puckett suddenly announced his decision to resign for family matters, including clearing the way for approval of his daughter as a juvenile court judge (the Senate had a history of declining to confirm direct relatives of lawmakers as a matter of policy). Democrats accused Republicans of masterminding Puckett’s resignation by promising him a job in the Virginia tobacco commission (a Republican member of the House of Delegates was the commission’s chairman) and speeding the appointment of his daughter to the state judgeship. In the face of this uproar Puckett withdrew his name from consideration for the tobacco job, but still stepped down from his seat and flipped control of the Senate to Republicans (Gabriel 2014).

In the face of a $1.55 billion revenue shortfall, on June 12th Senate Republicans used their new majority to pass a budget that not only failed to contain any form of Medicaid expansion, but also included language that prevented expansion without approval of the full General
Assembly (essentially eliminating any opportunity for McAuliffe or the legislative commission to implement an expansion on their own). After approving a floor amendment that barred spending for Medicaid expansion or a private alternative without approval of both houses of the GA, the Senate voted to approve the budget and the House of Delegates soon followed. McAuliffe criticized the act for moving the commonwealth backward by “violating the terms of the bipartisan agreement [the GA] reached in [the previous year’s] budget.” Democratic Senators called the decision to deny access to life-saving coverage “immoral” and accused Republicans who had previously supported health care expansion of caving to pressure generated by Tea Party activists (who were emboldened by the early June primary defeat of House Majority Leader Eric Cantor) (Martz and Nolan 2014a).

Calling Medicaid expansion a “moral imperative,” McAuliffe vetoed the Senate amendment and the budget language that created the Medicaid commission, directed his cabinet not to attend or assist with any more “meaningless” MIRC meetings, signed the budget that did not include an expansion of Medicaid, and promised to move forward unilaterally to expand coverage (Martz 2014b). In response, House Speaker William Howell ruled McAuliffe’s veto of the amendment of budget restrictions on his ability to use federal funds for health coverage without GA approval unconstitutional, and prevented a vote in either the House or the Senate on whether to override the veto. On the same night, Senate Republicans used their newfound majority to seize chairmanships of all Senate committees (Martz 2014c).

In a move intended to show that Republicans were willing to discuss expanding Medicaid as long as the matter was divorced from the state budget, Republican leaders called the Virginia House and Senate back to Richmond for a special session in September. During this session, the GA was able to repair the two-year state budget to address a $2.4 billion revenue shortfall and
fill a number of vacant judgeships, but failed to resolve how to provide health care coverage to uninsured Virginians. The House voted 64-33 not to advance a proposal by Republican Delegate Thomas Rust to Create the Virginia Health Care Independence Act as a way to use federal funds to buy private insurance coverage for the uninsured (Martz and Nolan 2014b).

With the 2014 expansion effort officially dead, the Governor used his executive authority to launch “A Healthy Virginia.” This plan was intended to maximize coverage already available to Virginians (which he said would result in dental care for 45,000 pregnant women, health insurance access for 20,000 severely mentally ill Virginians, and the expansion of FAMIS benefits which would bring health insurance to 5,000 children of state employees who were not previously eligible). Many saw this as McAuliffe’s acknowledgment of the limits of his power to act unilaterally, since this action expanded coverage for far fewer people than the 400,000 who would be eligible under a full Medicaid expansion (Nolan 2014b).

In December, McAuliffe introduced language to expand Medicaid in his proposed budget for the GA session that started on January 14, 2015. However, both houses rejected Medicaid expansion in separate (but similar) budget bills passed in early February. Senate Democrats (now in the minority) could not even muster the votes to block a GOP motion to cut off debate on Medicaid before it began (Vozzella and Portnoy 2015). Despite the fact that public opinion supports the expansion of Medicaid by more than 2-to-1 margin (according to a statewide survey) (Farnsworth 2015), most observers see the prospects for Virginia expanding Medicaid this year as a long shot given that 2015 is an election year and not much has changed in terms of the stark GOP resistance in the Virginia GA (Nolan 2014b).
ARIZONA BACKGROUND

Just as it did in Virginia, the prospect of a Medicaid expansion occurring in Arizona after the June 2012 NFIB v. Sebelius ruling appeared bleak. Arizona had been one of the 27 states that sued the federal government over the ACA, and the state’s Republican governor Jan Brewer, who was famous for a photo depicting her waving her finger at President Obama on a tarmac in Phoenix, was firmly opposed to the ACA. In an initial reaction to the Supreme Court ruling Brewer stated, “If nothing else, today’s decision officially sets the stakes for the November election. It is now up to the American people to save our country from the fiscal and regulatory nightmare known as ObamaCare…If Arizonans are to have access to the health care they need from the provider they choose, ObamaCare must be fully repealed” (“Reactions to Shocking Decision on Obamacare” 2012).

An additional factor affecting the state’s likelihood of expanding was Arizona’s recent move to scale back its Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). In 1996, Arizona voters passed Proposition 203, Healthy Arizona I, with 72 percent of the vote. Prop. 203 expanded eligibility for AHCCCS coverage to childless adults with incomes at or below 100 percent FPL, yet this initiative was never funded. A funding source became available, however, in 1998 when Arizona joined 46 other states in signing the Master Settlement Agreement with tobacco manufacturers—this contract provided Arizona with $3.2 billion over the first 25 years of the agreement. In 2000, Arizonans again voted to expand coverage to the population up through 100 percent FPL (in Proposition 204), yet this time mandated that the expansion be funded by tobacco settlement funds and “other available sources” (“Understanding AHCCCS and Proposition 204”).
In 2011, facing a daunting budget deficit at a time when Prop. 204 coverage was increasingly relying on funding from the state’s general fund, the legislature passed and the governor signed a budget that froze enrollment in AHCCCS for the Proposition 204 population. This action resulted in drastic declines in enrollment and substantial increases in the size of Arizona’s uninsured population. Overall, these cuts were estimated to save the state $260 million (Levy 2011). Subsequently, a group of plaintiffs filed a lawsuit claiming that the state had violated Proposition 105—the Voter Protection Act—by not providing sufficient funding to AHCCCS for the Prop. 204 population. The Court, however, found that the phrase “all other available sources” in Prop. 204 was not an appropriation, and thus the “availability” of funding was up to the legislature. The freeze was therefore allowed to remain in place (“Understanding AHCCCS and Proposition 204”).

In some ways, the state’s history regarding Medicaid coverage made expansion under the ACA an easier task in Arizona than in other states. Most states offer very little Medicaid coverage for childless adults, which means that an expansion to 138 percent of the FPL is a large step and even those states’ 10 percent share is a big bill (Robb 2013). But in Arizona, this was not as big of a jump because the state was already relatively generous with Medicaid benefits. The state’s history of providing coverage to individuals up through 100 percent FPL also allowed supporters to frame the action as a “restoration” rather than an “expansion” of coverage. But so soon after this large Medicaid scale-back, many argued that the state did not have the funds to support expansion to 138 percent FPL. An early July 2012 article published in the Arizona Capital Times opened with the statement; “If the feds can’t force Arizona to move forward with the massive Medicaid expansion, it’s a near certainty the Republican-led legislature won’t do it for them” (Duda 2012).
Like McDonnell in Virginia, Brewer took her time in announcing her official position on Medicaid expansion in Arizona. In November 2012, she declared that Arizona would not establish a state-run health insurance exchange. Just as Virginia did, Arizona would leave the job of setting up and running its exchange to the federal government (Celock and Young 2013).

While Brewer was still weighing her options, the non-partisan Grand Canyon Institute published a study that demonstrated the potential cost-saving effects of expansion. According to the nonprofit research institute’s 2012 estimates, expanding the Medicaid program could help save Arizona $1.2 billion and create over 20,000 jobs in the state over the following four years, and bring more than $5 into Arizona from the federal government for every dollar the state spends. The results of this study and others like it revealed the multiple ways an expansion would benefit the state as a whole, not just its low-income residents (Culp-Ressler 2012).

Before Brewer came to a decision, a plan was already in the works to develop a coordinated effort to push Arizona to expand Medicaid. In August 2012, a statewide group of human-services providers agreed to hire Chuck Coughlin (who ran Governor Brewer’s re-election campaign) and Peter Burns (a former state budget director who had a contract with Brewer’s office to provide an analysis of the ACA’s impact on Arizona) to spearhead an effort to create a coalition of hospitals, insurance plans, providers and other players to push Medicaid expansion through the legislature during the next session (Reinhart and Sanchez 2012). By that time, some hospital officials had already spoken out in favor of expansion, saying their hospitals could stand to lose millions if Arizona were to reject the Medicaid expansion (Culp-Ressler 2012).

In a surprising and influential move, Brewer came out in favor of expanding Medicaid in her January 2013 State of the State address. Justifying her unexpected decision, Brewer
explained that if she did not accept the Medicaid funds for Arizona, other states could claim those federal dollars, use the funds to grow their economies, and create additional jobs that would otherwise be generated in Arizona (Celock and Young 2013). Refusing the funds would also harm the state through the costs of providing emergency room care to uninsured Arizonans, which Brewer said would amount to a “hidden tax” of $2,000 per family (Fischer 2013a). After saying that the law was an unavoidable reality and that her state would be worse off turning down the federal money, Brewer argued that the federal funding would help pay for some individuals already covered by AHCCCS and provide some protection for rural Arizona hospitals. Addressing the concern that the federal government may cut back on its share of financing of the state expansion, Brewer said that her plan would include a “circuit breaker” which would automatically shrink the state’s Medicaid program in the event that the federal government were to decrease funding (Celock and Young 2013).

While Brewer’s support was a huge win for expansion proponents, the battle to expand Medicaid in Arizona was far from over. Lawmakers’ responses to her speech foreshadowed the battle to come—while a few Democrat lawmakers stood to cheer, most Republicans not only stayed seated but also refused to applaud (Fischer 2013a). Unlike in Virginia, where Democrats led the Senate for a significant portion of the state’s expansion battle, Republicans had (and still have) solid control over both houses of the Arizona legislature. After the November 2012 elections, Republicans held 17 out of 30 seats in the State Senate and 34 out of 60 seats in the House of Representatives (Republicans previously held a supermajority 40-19). Republicans had an even stronger majority in the House after the November 2014 elections, holding 38 seats in the House and retaining their 17 seats in the Senate (“Arizona” Balotpedia).
In the days following Brewer’s State of the State address, a split emerged between Republicans over the idea of expanding AHCCCS. The more conservative lawmakers did not want to see “Obamacare” expanded, some Republicans were willing to consider the proposal depending on the details, and others agreed with Brewer that expansion would be an economic generator and a smart move for the state. Significant Republican support in the state legislature would be essential for any expansion proposal to move through the legislature, especially given an informal GOP caucus rule that required measures to have support from a majority of the Republican lawmakers to advance to the floor (meaning that nine Republican senators and 19 Republican representatives would have to support expansion). The proposal would also have to move through the chambers’ Appropriations committees, both of which were chaired by Republicans staunchly opposed to the ACA (Stephenson 2013a).

Governor Brewer’s support for expansion drew fierce criticism from both state and national sources. The National Review said that Brewer was “bought off with a truckload of money from Washington.” The Wall Street Journal said Brewer committed a “spectacular flip-flop” when Arizona hospitals “cooked up a spending scheme to rip off national taxpayers.” Led by the Arizona chapter of Americans for Prosperity, a variety of conservative interest groups, including Americans for Tax Reform and the Goldwater Institute, attacked Brewer’s proposal and called it “the wrong choice for Arizona” (Duda 2013a).

In an effort to win support from skeptical conservative lawmakers who had remained noncommittal because they had not seen a bill, on March 12, 2013 Governor Brewer unveiled draft legislation that detailed her plans for AHCCCS expansion. The draft legislation was largely in line with the measures that Brewer had outlined in previous weeks. It included both the “circuit breaker” and the hospital assessment—a fee that would be leveled against hospitals to
help offset the state’s share of the costs. Hospitals were generally supportive of this measure as a small price to pay for the large financial benefits they would gain from expansion, while opponents of expansion called the assessment a “bed tax.”

In the face of such staunch opposition, the push for the governor’s expansion proposal came from multiple sources. The governor herself was hugely involved in this effort. Throwing all of her political capital behind the initiative while carefully framing the issue to appeal to conservative values by calling her expansion plan “pro-business” and “fiscally-responsible,” she travelled across the state to sell her message, flanked by hospital, business, and other industry leaders and professionals. In an early March public display of force before the legislature on the steps of the State Capitol, she surrounded herself with health care professionals and reiterated her key reasons for embracing expansion: broadening AHCCCS eligibility would save taxpayer money, save lives, and reduce the burden on hospitals caring for a growing number of uninsured patients. She also warned that without expansion, 50,000 Arizonans would lose their health coverage on January 1st. Opponents at the rally, including many local Republican officials, dressed in black to signify mourning after the Governor “betrayed her party” and warned Republican lawmakers that supporting expansion could end their political careers (Reinheart 2013a). Brewer threatened the opposite: in a letter to every Republican precinct committeeman in the state she warned that Republicans should back her plan or prepare for Democrats to win Arizona races in 2014 (Small 2013).

Much of the push towards expansion revolved around semantics—Brewer and her team sought to frame the proposal in a manner palatable to conservatives. Most pro-expansion advocates referred to the plan only as a “restoration” of coverage to those who lost it when the recession provoked an enrollment freeze rather than a Medicaid “expansion” (Santos 2013b).
Expansion advocates also touted restoration as a pro-business, fiscally responsible choice that was essential to Arizona’s economy. During a second rally in March at the state Capitol, Brewer linked the plan to strong conservative values when she stated, “I’ve always been proud to be a member of a pro-life party. With this legislation, we’re talking about people’s lives” (Reinhart 2013b).

While Brewer was the major face of this campaign, the push for expansion relied heavily on the exceptionally well-organized efforts of coalitions of interest groups. The central Restoring Arizona coalition led an effort supported by hundreds of groups/smaller coalitions (including hospitals and hospital associations, health care providers, consumer organizations, disease-specific organizations, state and local chambers of commerce, and other business associations) to organize and fund rallies, research, polls, lobbying efforts in the legislature, and other pro-expansion initiatives. Business associations and leaders involved in Restoring Arizona began running television advertisements during the 2013 legislative session promoting Brewer’s plan as a lifeline to hospitals, particularly in rural areas where the population of Medicaid recipients and the number of uninsured seeking care in emergency rooms was large (Santos 2013b). The Arizona Business Coalition (now called the Employers Health Alliance of Arizona), a Chamber of Commerce-led independent expenditure committee that was a major donor to Restoring Arizona, unveiled a television ad in early March that featured an image of Brewer flanked by five other Republican governors who are pushing Medicaid expansion, referred to the Medicaid proposal as “the Governor’s fiscally conservative Medicaid plan,” and ended by urging viewers to contact their legislators through the campaign’s website—restoringarizona.com. Spokesman for the Arizona Business Coalition Jaime Molera said that the initial ad (which was the first of
several) was meant to show Arizonans how much support there was in the business community for Brewer’s plan and to build up public support for the proposal (Duda 2013b).

Before Brewer unveiled the Medicaid bill she endorsed, 40 lobbyists representing at least 110 pro-expansion groups (including hospitals, health care associations, and business organizations) met in the executive wing of the state capitol to update the governor’s advisers on their progress and coordinate strategies. One lobbyist reminded colleagues not to encourage the interference of enthusiastic Democrats, saying later that using Democrats to win over Republicans in Arizona can prove disastrous (Santos 2013b).

AHCCCS expansion was a major issue of debate during the spring 2013 legislative session. With Arizona’s enrollment-capped Medicaid program for childless adults (which was frozen in 2011) set to be eliminated entirely on December 31, 2013 barring federal approval of a new application, it was clear to both sides that something needed to be done about the 60,000 Arizonans who were at risk of losing their health coverage on that date. But as an alternative to Brewer’s plan for AHCCCS expansion under the ACA, the GOP leadership in Arizona proposed maintaining the freeze and using state funds to cover those people (they suggested allowing people above 100 percent FPL to get subsidized health coverage through online insurance exchanges). However, in late April, Centers for Medicare and Medicaid Services (CMS) officials said that they were unlikely to fund a slimmed-down version of the state’s Medicaid program that included enrollment caps or similar policies. While Brewer used the federal memo to push her expansion plan (saying that it eliminated the GOP leadership’s alternative), Senate President Andy Biggs (a Republican) reaffirmed his vow not to bring Brewer’s proposal to the senate floor for a vote. Biggs, House Speaker Andy Tobin, and other Republican expansion opponents maintained that broadening Medicaid eligibility was fiscally unsustainable and that their plan
was still the best option whether or not the federal government agreed to chip in (Reinhart 2013c).

For many lawmakers, AHCCCS expansion’s implication for abortion funding was a major factor determining their position on Brewer’s plan. In early May, Republican Representative Paul Boyer, one of the lawmakers who stood with the governor when she first announced her plan, suddenly switched sides to oppose expansion. Boyer said that the change came after he read a letter by the Alliance Defending Freedom, which stated that expansion would “necessarily result in increased funding of abortion providers in Arizona to subsidize abortions.” While Boyer was originally open to amendments to satisfy his concerns about expansion increasing abortion funding, after reading the letter he felt that there was no way for the legislature to address the problem (Stephenson 2013b). Around the same time, Representative Carl Seel pushed a plan to kill the expansion proposal by including another “circuit breaker” that would end expansion if any of the new funding would go to abortion providers. Seel hoped that this play would deprive Brewer of the Democratic votes she needed to expand AHCCCS (Duda 2013c), but this plan did not make it into the final bill.

With the 2013 legislative session well past the 100-day mark, Brewer told lawmakers to stop sending her bills (an implied veto threat) until they at least made substantial progress on the budget and her Medicaid expansion plan (Duda and Stephenson 2013). She followed through on this promise in late May, vetoing bills on education and religious freedom that came to her desk before the Legislature adopted a budget or a Medicaid plan (Wrigley 2013). On May 15th, Brewer hosted another huge rally at the Capitol, gathering hundreds of people and standing with about 150 patients, health care providers, first-responders, and others to urge passage of her Medicaid plan. The event was emceed by radio host Mike Broomhead and had the aura of a huge
campaign rally, with speakers blasting music and hundreds of people waving signs in the crowd. The Chamber of Commerce-led Restoring Arizona committee set up tables on the lawn where people could call or email their legislatures to ask them to support expansion (Duda 2013d).

On May 16th, five Republican senators united with Democrats in a 19-11 vote to approve Brewer’s expansion plan. After beating back over a dozen amendments intended to weaken or undermine the proposal, the Senate approved a plan that was almost entirely in line with Brewer’s proposal. The one key change proposed to have the plan self-destruct at the end of 2016, forcing future lawmakers to revisit the whole issue (yet this provision did not make it into the final version of the bill) (Fischer 2013b).

With the July 1st Arizona budget deadline looming, in early June House Speaker Tobin announced that he would allow a vote on the governor’s expansion plan. Citing frustration over the lengthy stalemate with Brewer and a lack of support for his alternative proposals, he assigned the budget bills containing the expansion framework to committee while maintaining his opposition to Brewer’s plan (Wing 2013). After Brewer unexpectedly called a special legislative session about a week later, both chambers rode a wave of bipartisanship and approved a budget including Brewer’s Medicaid expansion proposal in the early morning hours of June 13th. In the House, nine Republicans joined 24 Democrats to approve the spending plan, and in the Senate, five Republicans joined the 13 Democrats to pass the budget (Republican Senator Michele Reagan joined the other five Republican senators to vote for the main budget bill, but cast no vote on all other budget items including Medicaid expansion) (Duda, Giles, and Stephenson 2013a).

On Monday, June 17th, Governor Brewer ended the five-month legislative battle and signed the expansion legislation into law. At the Medicaid signing ceremony, some of the 14
Republicans who defied their leadership to vote for expansion entered the room to a standing ovation. Brewer thanked and praised the bipartisan coalition of legislators supporting the bill, saying, “They did something we don’t see a lot in politics today, and that is courage…You put people before politics, and you stood firm in the face of personal attacks” (Reinhart 2013d).

In subsequent months, Brewer and expansion supporters worked hard to provide political help to Republican legislators who had voted for expansion in the face of threats that yes-votes would mean the end of their political careers. Some of these GOP legislators faced aggressive primary challenges from the right as a result of their expansion votes—as Duda et al. (2013b) reported in an Arizona Capitol Times article, “Grassroots Republicans promised to field ‘true conservative’ candidates against the ‘traitorous 14’ and run primary elections across the state to cleanse the legislature of the ‘turncoats.’” In April 2013, Brewer formed Arizona’s Legacy, an independent expenditure committee designed to support fundraising efforts for pro-Medicaid Republicans. A first fundraising event in May was co-chaired by four health leaders in Arizona—the Arizona Hospital and Healthcare Association, IASIS Healthcare, Vanguard Health Systems, and Reginald Ballantyne, a Vanguard executive—and brought in more than $200,000. A November fundraiser for Arizona’s Legacy boasted eight donors contributing checks of at least $25,000, and a September fundraiser for “health care heroes” brought in about $350,000, or roughly $27,000 for each of the 13 lawmakers (Richard Crandall, one of the original 14, left the legislature in August). Brewer even went out of her way to fundraise directly for some candidates—an October event with Brewer and representatives from the Tucson Medical Center and the Arizona University Health Network invited guests to donate $200-a-person to Republican Representative Ethan Orr (Duda, Giles, and Stephenson 2013b).

Ultimately, all but one of the 13 Republicans who ran for re-election held onto their seats. The
one legislator who did not win another term lost to a Democrat in the general election (after winning the Republican primary).

Just two days after Brewer signed Medicaid expansion into law, expansion opponents (led by an activist group called the United Republican Alliance of Principled Conservatives) filed paperwork to put a veto referendum on the 2014 general election ballot. The referendum drive sought to repeal the provisions of legislation designed to increase AHCCCS eligibility to 138 percent of FPL, as well as the part of the law which gives the director of the state’s Medicaid program the power to levy the hospital assessment (which was designed to fund Arizona’s $240 million share of the expansion bill). In order to put the measure onto ballot, backers of the initiative needed to collect 86,405 signatures before September 12, 2013, and a successful petition drive would have prevented Arizona from implementing the expansion until voters gave their approval, delaying the expected January 1st 2014 start date (Fischer 2013c). In the end, the petition drive was unsuccessful. Organizers fell about 5,000 signatures short of the requirement, which allowed the expansion to take effect as scheduled in 2014. Expansion supporters said the effort never gained momentum because voters did not buy opponents’ argument that it was a referendum on Obamacare, and Brewer said the failure demonstrated Arizonans’ support for her Medicaid plan (Reinhart 2013e).

The failure of the referendum initiative, however, did not mark the end of conservative challenges to the Arizona expansion. Shortly after the signature deadline, the conservative Goldwater Institute filed suit on behalf of 36 Arizona lawmakers who voted against expansion, as well as three other plaintiffs. The suit alleged that the vote passing Medicaid expansion violated Proposition 108, a 1992 amendment to the Arizona Constitution that requires a two-thirds vote for all tax increases (the expansion was passed with a simple majority). The Institute
also alleged that the expansion violated the state Constitution’s separation-of-powers clause because it delegates the legislature’s taxation powers to the AHCCCS director, whose agency was made responsible for collecting the hospital assessment. Expansion proponents, including Brewer, had long argued that the assessment is not a tax and therefore is not subject to Proposition 108 (Duda, Giles, and Stephenson 2013b). During the first court date in mid December 2013, attorneys argued over whether the 36 lawmakers had the right to sue over the expansion plan. The Goldwater Institute alleged that each of the legislators had suffered an individual injury because their votes were nullified when Prop. 108 was ignored, yet Brewer’s attorney argued that the only parties with the right to sue were the hospitals that were set to pay the assessment (and they had willingly agreed to the assessment component of the expansion plan) (Duda 2013e).

On January 1, 2014 Arizona’s Medicaid expansion went into effect. By mid July of that year, over 192,000 Arizonans signed up for the newly available AHCCCS coverage, and uncompensated medical care costs in the state had already decreased by 31 percent (falling to $170 million, down from $246 million in the same period the previous year) (Williamson 2014). Despite these early successes, the battle over the expansion’s legal standing continued to rage in Arizona courts throughout 2014. On February 8th, a Maricopa County Superior Court judge ruled that the Republican challengers lacked the right to sue (Christie 2014). However, in April 2014 the Arizona Court of Appeals overturned the trial court ruling, saying that the lawmakers do have standing to sue over the potentially unconstitutional “overriding” of their votes (Duda 2014). This Appellate Court ruling was then upheld in late December 2014, when the Arizona Supreme Court also ruled that the Republican lawmakers have the right to challenge the Medicaid expansion. In reaction to this news, Brewer said, “While I am naturally disappointed in today’s
ruling by the Arizona Supreme Court, it simply means that the state now has the opportunity to fully defend the merits of our Medicaid restoration law in superior court…I am abundantly confident that Arizona will ultimately prevail, and that the state will be able to focus on implementing one of the most meaningful and critical health care policies in years” (Evans 2014).

The Supreme Court setback to Brewer’s expansion plan came less than a week before the Governor was set to leave office. Facing the end of her two-term limit in 2014, Brewer endorsed moderate Republican Scott Smith, a candidate who had backed her position on Medicaid expansion (“Arizona Governor Makes Key Endorsement in Primary” 2014). However, with 37.2 percent of the vote, Doug Ducey, the Republican state Treasurer, defeated Smith (who came in second with 22.1 percent of the vote) (Ballotpedia) in the primary and went on to beat Democrat Fred DuVal in the November general election (Delreal 2014). While Governor Ducey has opposed Brewer’s expansion program and argued for replacing it with a more conservative alternative, he has shown some reluctance to dropping out of the ACA expansion program that adds money to the state’s budget and is still deciding whether to continue the state’s defense of the expansion program in the lawsuit (Pitzl 2015). Given Ducey’s ambiguous stance, as well as the scheduled return of the lawsuit to the Maricopa County Superior Court for consideration of whether the hospital assessment funding mechanism violated the Arizona Constitution, the future of Arizona’s Medicaid expansion program remains uncertain.
Interest Group Coalition-Building

Interest groups from a variety of fields—including hospitals, health systems, chambers of commerce, health insurers, and consumer organizations—mobilized to support the fight for Medicaid expansion in Virginia. The Healthcare for All Virginians (HAV) coalition was one of the main organizations working to push Virginia to expand. According to Jill Hanken, Senior Health Attorney at the Virginia Poverty Law Center (VPLC) and leader of the HAV coalition, HAV was in place even before the passage of the ACA and has grown to be a coalition of 109 supporting organizations (as of 2015). HAV supporting organizations include health clinics, disease-specific groups (e.g. the Virginia Breast Cancer Foundation, the Virginia Hemophilia Foundation, and the American Heart Association), doctors’ and nurses’ organizations (e.g. the Virginia Council of Nurse Practitioners and the Virginia Chapter of Doctors for America), and a wide variety of other public interest-oriented groups (e.g. Voices for Virginia’s Children, Planned Parenthood Advocates of Virginia, and the Virginia Coalition of Latino Organizations) (havcoalition.org) (see appendix for complete list of HAV supporters). The HAV coalition’s steering committee was composed of representatives from supporter organizations as well as organizations not listed as HAV members (the committee includes representatives from VPLC, The Commonwealth Institute, the Virginia Health Care Foundation, the Virginia Hospital and Healthcare Association, AARP Virginia, the Virginia Association of Health Plans, and the Medical Society of Virginia) (Hanken 2015).

According to Hanken, while HAV previously worked on ways to try to expand coverage for low-income people, protect provider payments, and other similar issues, after the passage of the ACA the coalition shifted its focus to successful implementation of the ACA in Virginia. Over the past three years, implementation of a Medicaid expansion has been the coalition’s
single priority. “Throughout this, the HAV coalition, we work with our supporters, we meet with our supporters, we collaborate and strategize with our supporters, and the coalition will continue to do this work until it’s done” (Hanken 2015).

While there were significant efforts at coalition building around this issue in Virginia, the push for expansion as a whole was not entirely coordinated through one overarching organization or coalition. According to Hanken, while the Virginia Hospital and Healthcare Association (VHHA) was part of the HAV coalition’s steering committee, they chose to do their advocacy separately from the coalition. Chris Bailey, Executive Vice President of VHHA, explains the choice to advocate separately as a tactical decision. He states:

> We coordinated activities with the coalition that Jill [Hanken] led, we shared intelligence on messages that would work. You know, we made a tactical decision…they were the passionate advocates for just straightforward Medicaid expansion. We were trying to make a case for something that is Virginia-specific and Virginia-unique. Just a different way to get to the same outcome…We coordinated and we worked out parallel paths but they were done separately. We worked hard to make sure they complimented each other (Bailey 2015).

State and local chambers of commerce were another source of advocacy for expansion. Samantha Quig (2015), Manager of Government Affairs at the Virginia Chamber of Commerce, explains that the Chamber advocates for Medicaid reform and expansion as a component of its long-term (eight-year) economic development plan for the state known as “Blueprint Virginia.” After reforming the state’s existing program, the Chamber proposes that the General Assembly reject a federally-designed Medicaid expansion and instead seek a federal waiver for a Virginia-unique, private option coverage expansion plan. According to a Virginia Chamber position paper, the Chamber supports a private option plan because it is based on free-market principles, allows for greater oversight, and will “provide the Commonwealth the greatest return on its investment.” The Chamber also argues that the unique Virginia approach to expansion should
include, among other provisions, a requirement that enrollees be employed or actively seeking employment and a mandate that the private option plan be renewed at least every four years after an audit of the state’s Medicaid program ("The Business Case for a Medicaid Private Option in Virginia"). Interestingly, according to Quig (2015), the Chamber does not see the fact that Virginia did not adopt an expansion after the hard-fought battle in 2014 as a failure. Since it supports expansion as a component of a long-term plan, the Chamber is not in a rush to implement expansion immediately and maintains that Virginia must reform its existing Medicaid program before expanding.

The Chamber worked primarily with VHHA (and to a lesser extent, with VAHP) in their lobbying efforts. As Hanken (2015) explains, VHHA (rather than HAV) was the main organization coordinating with and pushing the efforts of the state and local chambers of commerce:

VHHA was very, very engaged, especially last year in promoting expansion, and so they worked very closely with the State Chamber of Commerce and some local chambers of commerce to support expansion. So the chambers were definitely part of the effort…and I would say they were pushed along more by the Hospital Association than they were by the HAV coalition.

When asked whether the Chamber ever coordinated advocacy efforts with the Healthcare for All Virginians coalition, Quig (2015) had surprisingly never heard of HAV. However, she remarked that many of the groups active in lobbying for expansion focused largely on the social and moral arguments for expansion (from her perspective, at least), whereas the Chamber was more focused on economic/business implications of expansion (e.g. controlling health care costs (especially to businesses) and ensuring a sustainable, cost-efficient program).

Stephanie Lynch, Director of Medicaid Innovation at the Virginia Association of Health Plans, says that while there were some “looser organizations” formed around the Medicaid
expansion issue, she does not believe there was an official coalition between all the stakeholders. Lynch (2015) states:

There’s different coalitions that were kind of circulating around…I believe it’s called Voices for Virginia Health Care…There were a couple looser organizations that were formed as a result…There was no official coalition between all these entities, to answer your question. But did we all work together to kind of lobby and talk to the same representatives, and kind of use the same strategy and the same kind of talking points? Um, yes, I would say that’s a fair thing to say.

Governor McAuliffe also played a huge role in the push for Medicaid expansion. But while he coordinated his lobbying efforts with multiple key interest group leaders, his efforts were not coordinated specifically through the HAV coalition either. When asked whether Governor McAuliffe’s pro-expansion efforts were coordinated with the HAV coalition, Hanken (2015) responded:

I wouldn’t say specifically with the HAV coalition, but definitely in collaboration with consumer groups and health providers throughout the state…Last year we were having weekly meetings at the governor’s office as we were attempting to coordinate with the governor’s office so they knew what we were doing and they would have a better sense of what we were doing. So there was coordination. But it wasn’t, you know, technically, formally with the HAV coalition even though a lot of the folks around the table were members of the HAV coalition, it was, you know, with AARP and with Planned Parenthood and all the separate groups who were invited to participate in these meetings, they just all happened to be part of the HAV coalition.

While it appears that the governor coordinated his efforts with the major organizations leading the interest group push for expansion, it is unclear whether the governor’s plans and strategies were relayed effectively or completely to the many HAV supporters and other organizations whose leaders were not in attendance at the governor’s office meetings. According to Hanken (2015), the Virginia Chamber was not regularly in attendance at these meetings. To some interest group leaders, coordination was a significant weak point of the pro-expansion campaign. Karen Cameron, Director of Virginia Consumer Voices for Healthcare (a multi-constituency consumer coalition that is also a HAV member), states, “To me, one of the issues is
we haven’t really had coordination to a large degree, for the outreach and education piece, and that’s something that we’re going to have to do in the off-season if we’re going to make a dent in this issue” (Cameron 2015).

In addition to the lack of complete coordination through a single overarching organization or coalition, another weakness of the Virginia coalition building effort cited by interest group leaders is the lack of adequate funding for this initiative. Hanken explains:

You have to realize, this coalition, we don’t have any funding, we’re just all volunteering to support this effort this way. When we first built the HAV coalition, whenever that was, we did get some voluntary donations from some of the supporters. That’s been our only, I mean, that’s been a little bank of money that we’ve used over the last five, six years to do the work that we do. But no one’s paid to run this thing…There are funded coalitions in other states, but ours is not funded.

While the HAV coalition was not well funded, VHHA did invest significant sums of money in their lobbying effort in favor of expansion. Bailey (2015) explains:

[Medicaid expansion] was the only priority for us last year, so our advocacy budget, we reached that…we spent a few million dollars a year…it was the number one priority so virtually the only thing we worked on was trying to get Medicaid expansion done. That’s not completely true, but 90 percent of it. Beyond the usual, we spent an additional million dollars on a whole variety of strategies to try to make the policy case to persuade the elected officials to move forward.

Although this issue was a priority for VHHA, Doug Gray (2015), executive director of the Virginia Association of Health Plans (VAHP), explains that other groups were not able to focus all of their resources and political capital on this one issue alone. He states, “You have to keep in mind there are other things in the world going on than Medicaid expansion, lots of things. And everyone’s working on those things. And so to the extent that anybody has other issues they’re working on, they can’t put all their eggs in one basket, and no one does.”

Another potential weakness of the Virginia coalition-building effort was the fact that the HAV coalition (as well as some other interest groups) were mainly active during and
immediately before and after the legislative sessions, rather than year round. According to Bailey, VHHA’s lobbying efforts were strong during the off-months and the time leading up to the legislative sessions in order to get momentum behind their priorities. When asked about the HAV coalition’s activity during the off-months, Hanken (2015) explains:

We’re primarily active during the legislative session, but we do stay in touch throughout the year. And of course last year, when the special sessions continued in April, June, and September, we were fully engaged throughout the year. This year we’ll stay engaged throughout the year because it’s an election year, but then it’s during the session that we meet on a weekly basis.

However, from Cameron’s perspective, HAV’s lack of engagement during the off-months is a flaw in their overall advocacy initiative. She states, “They function primarily during the legislative session and right before and right after. They don’t function a lot outside of that.”

A final potential weakness is the Richmond-centered focus of the HAV coalition (and some other pro-expansion organizations). Virginia Consumer Voices for Healthcare (VCV) Health Policy Analyst and Advocate Erin Steigleder (2015) explains:

The policy effort in Virginia has historically been concentrated in Richmond…There is very little coordination across different regions of the state, there is very little participation from other regions during the General Assembly sessions, because they think oh, everybody goes to Richmond, they make all the decisions, we have no impact. So there wasn’t really a lot of reaching out to even local organizations in different regions of the state, particularly Southwest Virginia which has the highest number or proportion of people who would be newly eligible for Medicaid if we did expand. There was very little effort last year before the General Assembly session to reach out to those groups so that we could use them during general Assembly. And then we found ourselves scrambling during the session saying, ‘Who knows someone in this county?’ ‘Who knows someone who could talk to this legislator?’ And because everyone had such a strong Richmond focus, we were at a loss as to who to talk to. And that’s something that really hit us hard.

According to Cameron (2015), although there was participation from the Virginia Chamber of Commerce, many of the smaller, local chambers of commerce were not very involved in the fight for expansion. While Quig (2015) says that around 20 local chambers of
commerce were involved in advocating for expansion, she explains that most of the Virginia Chamber’s coordination with the local chambers was done by sending emails about the state Chamber’s lobbying activities and distributing the Virginia Chamber’s position paper on the issue. Given this apparently limited coordination, the true extent of the local chambers’ involvement is unclear.

One group that has done grassroots organizing outside of the Richmond area, according to Steigleder and Cameron, is Virginia Organizing. This “hyper-local” grassroots organizing group works on neighborhood and statewide issues of interest to their members. However, Cameron explains that this group was not able to reach all parts of the state on its own:

It seems like they’re doing a lot in some of the local communities, and I think in between sessions they’ve been able to put a little pressure on some of the legislators. But the reality is that it’s kind of sporadic, it’s hit or miss. It might be this community has a group, and then you might go over 45 minutes and then another group in another community, so it’s not, it’s sporadic. It’s hit or miss.

When asked directly about whether the efforts to mobilize the public were really throughout the state or concentrated mainly in Richmond and the surrounding areas, Hanken (2015) states that she believes the really good grassroots work happened outside Richmond, particularly in Southwest Virginia and South Side Virginia. However, she then goes on to talk primarily about Governor McAuliffe (along with the secretary of health and human resources) traveling throughout the state to speak at press conferences and with Virginians outside of Richmond. Therefore, it seems possible that the governor rather than the HAV coalition or a significant number of interest groups did a large portion (or even a majority) of the grassroots work outside of Richmond.

**Messaging and Primary Arguments**
Interest groups, politicians, and citizens opposing Medicaid expansion in Virginia made a variety of different arguments to support their position. One common argument suggests that the population that would be covered under expansion is “undeserving” of this investment. As Gray (2015) explains:

[Virginia legislators opposed to expansion] articulate most of their concerns around the idea of providing coverage to someone who is, in their view, able-bodied. They think that because they’re able-bodied…they’re just lazy, basically. That’s the argument they make. I mean, the truth is far from that. There’s a large number of people below 138 percent of the federal poverty level who have mental illnesses or other challenges that make it impossible for them to hold a full time job with benefits. Not to mention there not being many jobs with those benefits.

Efforts to counter this argument had mixed success. One of the most effective ways of refuting this argument in many states has been to publicize individual patient stories, particularly of patients who appear sympathetic to expansion skeptics and do not fit the stereotype of the “typical” Medicaid recipient. Steigleder (2015) explains that interest groups hoped to gather these stories through navigators—trained individuals who assist consumers in health plan enrollment through the Marketplace. However in 2014, according to Steigleder, navigators’ concern about violating the strict restrictions that legislators tried to place on them made navigators reluctant to seek out stories (an activity that may have been viewed as “advocacy work”). After the first year of enrollment, the situation was a bit more relaxed and navigators were able to help interest groups put together a “story card.” Cameron (2015) later adds that the work on story collecting is ongoing, and VCV is currently attempting to put together a collection of stories highlighting citizens from each region of the state.

Steigleder also explains that one creative approach to countering this argument about the coverage gap population being “undeserving” that was taken by VCV involved emphasizing the fact that there are many veterans in the coverage gap. VCV expected that veterans would be a
sympathetic group. However, according to Steigleder the legislators came back and said that not all veterans are honorably discharged, and it is the individuals who are not honorably discharged that do not qualify for veterans’ services. In other words, they argued that the veterans in the coverage gap are there because they did something wrong.

According to Cameron, VCV and Virginia interest groups were reluctant to use the fact that people die without access to health insurance as a pro-expansion argument because their national partners discouraged them from doing so. The national advisors have seen mixed results in states that have used this argument—it has worked in some cases but in others it has backfired and put people on the defensive.

A second major argument against expansion in Virginia has been that the state cannot afford the 10 percent of expansion costs that the federal government eventually will not cover. According to Hanken (2015), however, that is a deeply flawed argument that pro-expansion groups in Virginia do not accept. When asked whether this argument about even the 10 percent state share being too steep is compelling in Virginia (or more compelling than in other states), Hanken responds:

Well I don’t think it’s really true…We push back by reminding them about not just the money that could be brought into the state, but savings that could be derived from state programs that would allow us to save state dollars and even potentially bank those state dollars for use in future years. However, the longer we wait to expand coverage, the less we are able to save those dollars at the front end and use them down the road. When you think about the impact of two billion dollars a year in a state, it’s just an enormous financial benefit in terms of the multiplier effect, and the additional income taxes that are generated, and the jobs and related taxes. You know, we don’t accept that position at all that Virginia can’t afford it. Virginia is one of the wealthier states in the whole country. And we can afford it and there’s some real savings to be achieved that we’re forgoing by delay.
Karah Gunther, Director of Government Relations for the Virginia Commonwealth University (VCU) and VCU Health Systems, offers a similar answer, explaining that Virginia is not unique in going through budget difficulties in recent years. She states:

Every state has budget woes right now. I mean, I think you can look across the country and see that all states have budget woes. And it is true that Medicaid takes up a pretty large portion of our existing budget. But I don’t think that we’re unique. I think that that’s the case in every state and I think there are certainly some states that are worse off than us financially that have pursued or explored a Medicaid expansion. And it’s because they’ve seen the savings that are associated with it. And it actually can end up becoming an economic driver in these first few years before the 10 percent ultimately goes into effect (2015).

Gray (2015) highlights another angle from which pro-expansion groups were able to counter the expansion is too expensive argument: the idea that expansion would mean shifting around the dollars that were already being spent (inefficiently) on health care for low-income individuals rather than adding new dollars. He states:

We tried to help [the legislators] understand the benefits to the consumers, we tried to help them understand that there’s a cost shift in that insurance costs more when there are uncovered, uninsured people, we tried to help them understand the fundamental concept that we’re already spending the money taking care of these folks, we’re just spending it at the wrong time. We’re spending it at the ER, after they’re already too sick to be helped, instead of helping them at the front end with preventative care.

A third argument that expansion opponents in Virginia make, according to Gray, is that Virginia should not take federal money for expansion because federal money is “bad money.” However, he finds this argument flawed as well. Gray argues:

The we-don’t-take-federal-money-argument is pretty weak in a state that really brings down the money…I mean, Virginia’s got all of the federal contractors, defense and otherwise, and northern Virginia, huge military presence in northern Virginia with the Pentagon, huge military presence in Southeastern Virginia with the shipyards and air bases. Not to mention army bases in the middle of the state, I mean, we really pull down the money. But never mind, this is bad money.

In Virginia, as in many other states, effectively framing the pro-expansion message in a conservative-friendly manner was a major goal of the interest group campaign. When asked
about the effort to frame expansion in a manner that would appeal to conservatives, Bailey explains that VHHA commissioned a poll and a focus-group research series on Virginians who were active in Republican primaries and self-identified as either Tea Party or strongly conservative. These studies were designed to identify messages in favor of expansion that would be persuasive to that conservative group. The first conclusion, which came as no shock, was that participants had strong negative opinions of President Obama. This suggested that pro-expansion advocates should avoid mentioning the president’s name in connection to Medicaid expansion. A second result emphasized worries about expanding an entitlement plan. But interestingly, the research suggested that if the case for expansion could be articulated as a plan to help lower-income, working Virginians who play by the rules like everyone else, even a majority of the Republican participants could be convinced to support moving forward on expansion. In practice, though, this was actually difficult to achieve because expansion opponents could negate the effects of this argument very quickly and easily. As Bailey explains, “The problem was that on the other side, all [that opponents] needed to do was scream ‘Medicaid,’ ‘Obama,’ ‘Medicaid expansion,’ and that tenuous support you might have amongst that constituent would be set back.”

Despite these efforts to research effective messages, Cameron (2015) is critical of Virginia interest groups’ lack of coordination in using these responses. She states, “There wasn’t good enough coordination of talking points. I mean, we had talking points, but it was kind of like let’s get everyone to come and use them as you will, kind of thing.” In making this point, Cameron implies that interest groups’ failure to speak with a completely unified voice was a weakness in the pro-expansion advocacy strategy that may have limited their ability to clearly communicate their message to legislators and the public. Quig (2015) offers further evidence that
expansion proponents in Virginia took a divided approach to messaging. She states that while the Chamber had general talking points that were distributed to other organizations including VHHA, they were used primarily just by the state and local chambers. Even VHHA, the Chamber’s close partner, had its own separate talking points.

**Lobbying Legislators Directly**

A large portion of the lobbying strategy in Virginia centered around interest groups explaining their positions on the Medicaid expansion issue to the legislature (or individual legislators), and educating legislators about why they believe expansion is in the best interest of Virginia and their individual group. Bailey describes VHHA’s priority in this regard as trying to cut through the partisan bickering and get legislators to focus on what expansion would mean for the state of Virginia. He explains:

I think we had one…overall objective with the General Assembly that we tried to achieve, and that was to get them to focus on what’s best for the commonwealth on this issue. Forget about the national politics, forget about what’s happening in the other states with their Medicaid programs. What are the plusses and minuses for the commonwealth of Virginia? And that’s who they’re elected to serve.

Bailey says that VHHA used every “typical tool in the toolkit” during the protracted 2014 session in the attempt to convince Republican legislators to support expansion. According to Bailey, these “tools” included publishing op-eds, convincing the business community to stand up in favor of expansion, and producing a number of research studies that would help them make the policy case for expansion.

Gunther (2015) explains that the VCU Health System felt pressure to exercise caution in its approach to interacting with and lobbying the legislature. Given VCU’s position as a state public teaching hospital rather than a private hospital that can give money or donate money to candidates, she says that they have “always really…strived to be more of an educational resource
for legislators rather than a true lobbying arm.” However, expansion is of crucial importance for them because the VCU Health System is the largest provider of care for uninsured and Medicaid patients in the state, and the System will therefore be placed in a very perilous position when the ACA cuts to Disproportionate Share Hospital (DSH) payments go into effect. VCU has consequently been very active in educating the legislature on this issue by testifying before money committees of both the state House and Senate, helping VHHA host educational forums and discussion forums for legislatures, meeting one-on-one with several leaders in the General Assembly, and offering expertise in the process of crafting alternative 1115 waiver plan proposals for legislative consideration. VCU also worked closely with VHHA to host forums and meetings for targeted groups of legislators in coordination with many of VCU’s direct competitors—private hospitals that share the Richmond region and the University of Virginia (UVA) hospital (the other state teaching hospital in the region). Describing meetings that VCU and UVA did together with leaders of the House and Senate money committees, Gunther states:

> Our thinking was, you know, we do compete, we compete with the other academic medical center. And the message was you don’t see us here together often. In fact, we compete quite a bit but we’re here together to talk to you today, and I think that was pretty powerful, you know, that the two flagship teaching hospitals were making the rounds and connecting visits together. So we did quite a few of those visits.

> The Virginia Association of Health Plans’ lobbying efforts on expansion mostly came in the form of educating various legislators about the Association’s position on the issue and readiness to provide Medicaid coverage to the expansion population through a managed care approach. Gray (2015) explains:

> What we did was articulate to the legislators the history of managed care in Virginia and how prepared we are to handle the job of providing Medicaid coverage through a private insurance product, through managed care. And so we helped educate them about the 700,000 people we insure, that we have competition in every region of the state with a minimum of two and sometimes as many as six carriers competing with one another, and
how we use that approach to create an effective product that gives a lot of consumers good choices and access to care.

According Lynch (2015), however, VAHP was limited in its ability to be a leader in the pro-expansion lobbying effort by the diversity of stances taken by its members. Many member plans were passionate supporters of expansion (particularly the Medicaid managed care organizations) while some other plans took no stance on the issue. Although none of the members took a strong stance against expansion, Lynch explains that VAHP’s obligation to represent the interests of all of its members (including those that refrained from taking a position on expansion) restricted the Association’s advocacy activity. She states, “Each of the plans kind of took their own stance on [Medicaid expansion], so as far as the Association to be out front, we weren’t viewed as one of the out front runners advocating, certainly not as much as folks like VHHA.”

Gray (2015) explains his belief that the largest obstacle to winning support for expansion in the GA was the Republican leadership’s unwillingness to allow other Republican legislators to vote for expansion and “betray” their party. He states, “I philosophically believe that there’s probably enough people in the Republican Party that want to vote for this along with the Democrats. The problem is their leadership won’t let them, because they’re afraid they’ll get blamed for it. And so there is no real vote on it.” Delegate Jennifer McClellan, a Democrat representing Virginia’s 71st district, agrees with this notion that a lot (or even a majority) of legislators in both chambers of the General Assembly philosophically believed that expansion was the right choice for Virginia—she argues that most Republicans did not vote for it because either the leadership would not let them or they were afraid of being defeated in the upcoming primary elections. When asked why the leadership in Virginia has such clout and was able to maintain such strict party cohesion, McClellan explains, “It’s the huge majority, it’s that the
speaker is extraordinarily powerful. He makes all of the committee assignments and...he decides who speaks on the House floor. If he wants to shut you out he can.” In other words, delegates feared that going against the leadership on the Medicaid expansion issue would restrict their influence in the House more broadly (on issues both related and unrelated to health care policy) (McClellan 2015).

While Hanken believes Virginia interest groups mounted a very strong campaign for expansion (in 2014 especially), and is hard-pressed to think of areas in which Virginia interest groups’ pro-expansion advocacy strategies could be improved, the one thing she does mention is attacking the legislators’ rhetoric in a more direct, personal way and demanding better answers from them. Hanken states:

I really think we had…a very strong campaign last year, and we did everything that we really could have. I mean, you could always do more in legislative advocacy. I think that in Virginia there’s a tradition of polite disagreement and...while we tried to ratchet up and beat the rhetoric from the other side, you know, I think we probably could have ratcheted up harder and in a more personal way, demanding better answers from a lot of the legislators who just stuck to their talking points and refused to answer a lot of the questions.

One additional factor of potential influence regarding the direct lobbying strategy is the partisan nature of this effort in Virginia. Lynch (2015) explains:

The Democrats were the ones that were charging this issue and were for this issue, and the fact is that there were some Republicans who were more helpful than others, we’ll say. But the Democrats were the party of charge when it came to Medicaid expansion, and it was a Democratic initiative, and so most of the work had to be done with the Republican leadership.

While this idea is not surprising given that Democrats are clearly more likely to support most aspects of Affordable Care Act implementation than Republicans, recognizing the fact that this was so strongly a Democrat-driven initiative within the General Assembly may prove important in later comparison with the Arizona case.
Grassroots Initiatives

Overall, interest group leaders in Virginia generally admit that the grassroots organizing side of the push for expansion in the state was not as strong as it could have been. Hanken (2015) explains that many of the HAV coalition members are grassroots-oriented, and so there was a fair (yet less than ideal) amount of grassroots organizing happening through those groups. The individual member groups that Hanken points to as being grassroots-oriented with a constituency that gets engaged are Virginia Organizing, Planned Parenthood, Virginia Majority, Progress Virginia, and some of the “disease groups.” Describing the grassroots efforts of HAV coalition members, she states, “Last year there were numerous press conferences, several rallies, there were signs every day as the legislators would walk to session reminding them of the money they were forfeiting each day that expansion was delayed. So I think we could probably do better in our grassroots work, but there is a good bit of it going on.”

As Hanken mentioned, pro-expansion groups in Virginia did hold several rallies to attempt to mobilize the public to support expansion. However, overall, interest group leaders admit that these events were often not very well attended, and therefore were not as influential as pro-expansion groups hoped. Cameron explains, “The biggest problem we have, I think, is that the grassroots is not at the table. We haven’t really brought…a rally where you have, you know, a thousand people show up or two thousand people show up. And so it’s so evident in [the legislators’] faces.” In saying that it was “evident in [the legislators’] faces,” Cameron indicates that these poorly-attended events may have had somewhat of a detrimental effect, making it appear to the legislators that the public really did not strongly care about or support this issue.

Cameron (2105) also explains that the grassroots campaign for expansion in Virginia failed to effectively mobilize citizens to put pressure on their legislators. She states:
The other thing is working at the local level to have people impact their legislators—there was some of that that went on during the session, but I think what we need to do is produce a groundswell of people contacting their legislators and putting pressure on them throughout. And of course that takes a lot of resources and it takes coordination, and the problem is we just don’t have anybody with that level of resources to do that.

Delegate McClellan (2015) seconds this notion, explaining that more grassroots pressure on legislators may have made a difference on this issue. She states:

What was frustrating was the people who would benefit the most, you know, a lot of them live in these Republican districts, and they weren’t, they’re not advocates, they’re just regular people who are living their lives. And I think…if they spoke up and started putting pressure on their representatives, then you might see different results. But they’re not organized…I think if you have a grassroots swell of people in those districts who directly would benefit from [expansion], you know, it’s hard to ignore your voters.

Some individual hospitals and hospital leaders made efforts to educate and mobilize staff around this issue. Gunther (2015) said that she dedicated a great deal of time during 2014 to educating VCU physicians, nurses, and other staff in the hospital about what Medicaid expansion (or the lack thereof) would mean for VCU. She did this through presentations at large staff meetings, among other education strategies. Gunther also described an effort on the part of the VCU Health System’s leadership to encourage Health System employees to use VHHA’s VoterVoice tool (designed to help hospital and health system employees reach out to their federal and state legislators on important health care issues) to weigh in with their legislators on the Medicaid expansion issue. In a carefully worded email that came from the CEO of the VCU hospital and went to all employees in the whole health system, health system leaders made employees aware of the VoterVoice tool through which they could weigh in with their legislators and ask them to support expansion. The email made it clear, however, that taking this action was completely optional for employees. According to Gunther, responses to this email were mixed. She explains, “Some people responded saying, ‘Thank you, thank you, thank you! I’ve been looking for a way to weigh in with my elected official, I’d like to do more!’ And other people
were angry that the health system was suggesting that they should support something that they may not necessarily agree with.” Ultimately, however, Gunther thinks the positive feedback outweighed the negative feedback. Describing the outcome of this unprecedented step, Gunther explains, “I think this was one of the first times we had ever had a request like that out to our staff, so I think it really impressed on them the gravity of the issue. And it probably was a good thing that we used that very judiciously because I think it caught people’s attention.”

While these types of mobilization/grassroots initiatives may have taken place at some individual hospitals, VHHA, one of the major drivers of the pro-expansion push, failed to do much grassroots organizing at all. This appears to be a major flaw in the overall advocacy strategy in the state, given the huge number of health care employees whose voices were not utilized effectively. Bailey, Executive Vice President of VHHA, admits:

The one thing we have not done yet and we are going to be doing this year is taking advantage of the grassroots strength of the health care, hospital, and health system community. We’re major employers, there are several hundred thousand employees in health care, and they are not making their voices heard on this issue as powerfully as they could. So it’s been a game where the leadership of the health system is active politically but not the floor nurse. And I don’t mean that we want every floor nurse to be active politically working a campaign, but if we’re going to be successful here we need to make sure legislators hear from the health care community pretty regularly about the need to find a solution to this issue (2015).

When asked what VHHA plans to do differently to try to implement a more effective grassroots strategy, Baily explained that VHHA has hired a number of regional grassroots coordinators (many of whom are retired legislators), is putting together a variety of messages and communication tools for employee use, and will be holding town hall style meetings and employee education events. He says that because it is an election year, it is time for the voters who are health care workers to make their voices heard. However, given that much of the
momentum and energy around pushing Medicaid expansion in Virginia has faded in recent months, it seems that this effort may be taking place too late to achieve maximal success.

The Virginia Association of Health Plans was another organization that did not engage in much grassroots advocacy. Lynch (2015) explains, “There are some organizations that…do public forums, organize communities, organize their membership, there are some that have gone and done major press relations and different multimedia types of efforts. The Association [of Health Plans] has not.” Additionally, according to Quig (2015), the public was not a real target of the Chamber’s advocacy efforts on Medicaid expansion. She adds that the Chamber did not spend much additional money on this issue—most of the Chamber’s advocacy was done through hired lobbyists who were already on staff (they primarily engaged in direct rather than grassroots lobbying).

As a result of the overall weakness of grassroots organizing around the issue of Medicaid expansion in Virginia, some interest group leaders say that neither the public nor the legislators were well enough educated on this issue. According to Cameron (2015), interest groups in Virginia need to do a much better job educating the public in general, and especially key groups such as health care providers. She states, “Some of the groups that I would like to target are provider groups. What you find is that most health care professionals, even physicians, are really clueless about what the Affordable Care Act is and how, within the health care system, how it actually functions…Because these are the people who are dealing with the patients who are uninsured, they need to be much more aware.” Later in the interview, Cameron added that in her experience, she has found that many of the people who work on health insurance enrollment in Virginia “really don’t have the health care background to understand how to explain to the public why they should care.”
When asked about legislators’ education levels on this issue, Delegate McClellan (2015) states, “I think everybody was well educated, I just think they had their different ideas about what [expansion] would mean. So in a sense, some of them, no matter how much you debunked their arguments, they stuck to them.” However, Steigleder (2015) points out that this year, there is a newfound recognition that the lack of access to regular health care for many people who are stuck in the coverage gap is a major problem. Previously, according to Steigleder, many legislators argued that uninsured individuals could just go to the emergency room or to free clinics for care. But after receiving more education last year about what it is really like to try to get health care when you do not have health insurance, many legislators have backed off of this argument. Even though this may mark a step in the right direction, this improved knowledge would have been more useful had it come earlier while expansion was still a major legislative priority in Virginia.

While both Steigleder and Cameron recognize this lack of strong grassroots action in Virginia, they cited a lack of manpower and resources as reasons why Virginia Consumer Voices for Healthcare, their multi-constituency consumer coalition, did not do more in this area. Steigleder (2015) explains that while they tried to educate the public, there is only so much that three people can do (referring to VCV’s three-person staff). After discussing the efforts of Americans For Prosperity in Virginia, Cameron (2015) states, “For a fraction of the money [that AFP] spent on media, we could have probably had more grassroots going than you can shake a stick at.”

Additional Influential Factors

Gerrymandering
A major factor that most Virginia interest group leaders cite as inhibiting their advocacy success is gerrymandering, particularly of the House districts in the state. They explain that this unjust practice amplifies Republican concerns about losing their seats to primary election challengers from the right (especially since conservative groups frequently threatened to field such candidates in races against Republican legislators who “betray” their party by supporting expansion). Passionately articulating this frustrating problem, Gray (2015) states:

Our districts are written in a safe way, particularly in the House, for Republicans. I mean, there’s 68 Republicans [out of 100 total House members] in a state that has two Democratic senators and has voted for Barack Obama twice. That tells you that the districts are not written in an equitable manner…The more conservative you get with your districts the more you worry about a primary opponent. And that’s what these 68 Republicans were doing—they were worrying about someone from the right running against them rather than a Democrat running against them—they didn’t have any concern about a Democrat. So from their perspective, they were doing the right thing by philosophically tilting to the right and saying we didn’t want to take federal money.

According to Gunther, even though the expansion never passed, some of the Senate Republicans who supported expansion throughout most of the 2014 budget session will be punished for their actions in upcoming elections. She explains, “We cultivated some Senate Republican champions who have really put themselves out on a line for us, and are actually going to be ‘paying’ for that this coming year. Several of them are being primaried, so they have primary challengers who are probably a little farther to the right than they are.”

Steigleder (2015) explains that after House Majority Leader Eric Cantor’s loss in the 2014 Virginia primary election to a Tea Party challenger, there is increased fear in the state about the threat of getting “primaried.” She states, “Unfortunately, with the defeat of Eric Cantor last year in the primary by a Tea Party candidate—that really has energized a lot of Tea Party folks in Virginia saying that, you know, we really can take out establishment Republicans. And I mean, even our incredibly conservative speaker of the house is being primaried from the right.”
Given this context, Gray (2015) is doubtful that investing money in campaigns of candidates who might be more favorable toward expansion would be at all beneficial. When asked about this campaign investment strategy, Gray states, “No, I mean, that’s kind of ridiculous in a place where the districts are written to favor one side or the other...How do you beat them in a district that’s written for them? The short answer is that you don’t and so that would be a huge waste of money and a dumb idea.” However, Cameron (2015) has hope that there is an opportunity for moderate Democrats to take seats from Tea Party candidates in some districts. She states, “There are some that are in districts that, potentially, if you do get a right-wing candidate, a moderate Democrat could come in and potentially take their seat...depending on how radical [the Tea Party candidates] are, [moderate Democrats] could potentially win in those districts.”

**Gubernatorial Influence**

A second additional factor that may have made expansion more difficult in Virginia than other states (including Arizona) is the governor’s party affiliation. Governor McAuliffe’s position as a Democrat may have made him an alienating, polarizing figure and reduced the likelihood of gaining bipartisan support for expansion. However, when asked about whether enacting an expansion would have been easier if Virginia had a pro-expansion Republican governor, interest group leader responses are mixed. Gray (2015) is convinced that a Republican governor’s support would have made all the difference in the battle for expansion:

McDonnell, who has been convicted of a felony and is trying to stay out of jail, with just a few words could have made this a lot easier. But he chose not to. And it’s sad, I mean, I think he knew that it was the right thing to do, but he couldn’t bring himself to do it. And a lot of people think he couldn’t do it, or wouldn’t do it because of political reasons. He was thinking he was gonna get the opportunity to run for a higher office or something. I think it’s pretty sad when you put your ambitions in front of what’s right for the Commonwealth. But that happens, and there’s no question that he could have made it better, but he just chose not to.
Steigleder also sees Governor McAuliffe’s position as a Democrat as an added challenge, explaining, “Unfortunately I think part of the problem is that our current governor, McAuliffe, he ran on Medicaid expansion. So if the Republicans give an inch, then the governor would have won. And they can’t have that happen” (2015). Hanken (2015) takes a similar perspective, stating, “You see the states that are moving forward now with waiver proposals to expand coverage, it’s coming from Republican governors. I mean if there was a, more of a right-minded Republican governor in place that would take some of this partisanship out of the equation, which is one of our biggest problems.”

However, other interest group leaders express more uncertainty about this factor making much of a difference. Cameron (2015) explains that while she thought at one time that a supportive Republican governor would have allowed Virginia to expand, she changed her opinion after watching Tennessee’s Republican governor put forth an expansion plan that did not end up getting support from the Republican legislature. She continues:

From that perspective I think that it really wouldn’t have made any difference in the outcome of the legislature, unless you had a Republican who was extremely popular, and I don’t think we have any kind of leader in the state who is that popular. We just had the McDonnell scandal here, and he was pretty popular among a lot of Republicans, and they ran from him as fast as they could.

Gunther (2015) agrees with Cameron’s doubt that a Republican governor would have made the difference in Virginia. She states:

In the next election cycle, say that a fairly moderate Republican governor wins and that person is interested in implementing a Medicaid expansion. I actually don’t know that we’d get a lot farther than we are today. I actually think that it is more of the current leadership in the legislature that’s driving this more than anything…[A Republican governor] could make some difference, I don’t know if it would make all the difference though.

Lynch (2015) adds:
It really goes back to the way our districts are drawn. And so even if there was a Republican governor that said let’s do Medicaid expansion, I feel that the Tea Party influence is such that in the House…they may have called the Republican a RINO—a Republican In Name Only…So I almost feel that even if there was a Republican governor that wanted to try to expand Medicaid, he would have been met with a lot of abrasion in the House.

Gunther (2015) and Cameron (2015) add to this discussion by highlighting some of the advantages that came from having a Democratic governor, particularly after the legislature failed to pass a full expansion. Cameron says that with a Democrat (McAuliffe), Virginia has been able to invest significant funds in a successful drive to increase enrollment rates in the insurance Marketplace. Gunther adds that the governor’s “A Healthy Virginia” plan, which he introduced and implemented via executive action in September of 2014, cannot really be considered an expansion of Medicaid but is a step in the right direction. Among other changes, that program offered a limited benefit for the seriously mentally ill up through 100 percent FPL. Gunther sees this program as a kind of “bridge to expansion and reform”—perhaps this limited step will help the state slowly adjust to an extension of health coverage to a wider population.

State Health Policy History

A third additional factor that may have affected Virginia’s expansion battle is the state’s history regarding federal policy (and particularly health care policy) implementation (a variable that scholars Jacobs and Callaghan (2013) refer to as “past policy trajectory”). According to Hanken (2015), Virginia’s reluctance to expand Medicaid is in line with its trend of taking its time to implement federal programs. She states:

So it’s quite discouraging but it’s not the first time Virginia has taken a long time to take up important opportunities. So they were slow in adopting Medicaid when it was first available back in the 60s, they were slow in adopting or making a really legitimate children’s health insurance program in the late 90s and early 2000s, and now they’re taking their time on Medicaid expansion. It will happen at some point, but we know that these 2015 elections have to get done and then, I mean there are always excuses they
could make, because of course then we’re moving towards a presidential election in 2016.

Another element of the state’s policy history that some might see as making expansion more difficult to implement in Virginia than other states is the fact that the state’s existing Medicaid program is more stingy about eligibility than other state Medicaid programs. When asked about the importance of this factor, Hanken responds:

Well that cuts both ways. I mean on the one hand it makes the arguments much more compelling, I mean Virginia is a stingy state in terms of eligibility, so it has a lot of catching up to do. But it also means that the funding that would come into the state is huge to cover, you know, up to 400,000 individuals who could benefit. Including parents who right now don’t qualify unless their family income is at or under 50 percent of the poverty line, so you know the fact that we’ve had a stingy program makes our argument even more compelling. And with the 100 percent federal funding, it makes it even a better deal! So it cuts both ways because as I mentioned to you, Virginia has been reluctant in past years on past initiatives to move forward. It just has not been aggressive, quite an aggressive state in terms of benefit programs for low-income people.

However, Bailey (2015) approaches the question about this factor’s influence somewhat differently, focusing on the idea that covering an entirely different population makes expansion a large policy step for Virginia. He states:

Virginia’s tradition is to be very stingy on eligibility—cover the benefits generously once covered, but try to focus the program on the most needy. And everybody defines that differently. You know, mothers, pregnant women, their children, the elderly, disabled, so we’ve never covered able-bodied adults. And that’s exactly the people who benefit from this Medicaid expansion. And so that’s a big step for Virginia. We’ve also never had this 90 percent funding source to do so, so the economics are extraordinarily different, but it is a big policy step.

Future Outlook

Leading up to and during the 2015 General Assembly session, interest groups generally did not invest as much time, money, or political capital in campaigning for expansion as they did the previous year. As Gunther (2015) explains, this was largely due to the political reality of the situation:
I think collectively the hospital industry decided, you know, we will continue to educate about the impact, but we can’t, there’s just such a careful balance that has to be struck in terms of expending political capital when you know it’s not going to happen. You just have to be careful not to burn bridges or damage long-standing relationships that you’re going to need in the future. So I’d say we have not, there has not been a huge lobbying effort or push to push through any sort of Medicaid expansion plan this session just because of the political reality.

This pullback did not only take place on the part of the hospital community. Cameron (2015) states, “There are several key partners in HAV who have now pulled back. AARP, who has been very much active, is still active but not near to the degree that it had been the previous year.” Steigleder (2015) adds, “Also last year we had the Chamber of Commerce making a push for it…but they have stayed completely silent this year.”

Hanken (2015) explains how despite the HAV coalition’s continued efforts to push this issue in 2015, the reality of the circumstances made this campaign largely ineffective:

It was very clear [in 2015] that the legislature didn’t have any appetite for making Medicaid expansion a big deal again. We also knew we had a problem because all of them, all of the legislators are up for re-election in November of this year…Our coalition encouraged the governor to put language in the budget to expand Medicaid and he did do that, and we worked hard to keep the issue in the public eye, we had one press conference, a lobby day, people were on the ground lobbying legislators, but it remained partisan and the Democrats did not have the vote in the legislature to make this happen. So it didn’t happen!

Bailey (2015) is hopeful that the introduction of a hospital assessment funding mechanism into the state might help Virginia move closer towards expansion. When asked whether a hospital assessment funding mechanism has ever been proposed or discussed in Virginia, he states:

Not last year but that’s definitely on the table this year…So part of the budget that was passed last week does include language directing development of the hospital assessment program to finance both payment improvements for hospitals and health care providers for existing programs, but also, in many people’s eyes, to be there to support the state’s share of Medicaid expansion should that happen. So it’s not for sure we’re gonna do one but it’s very much in the mix this year.
In thinking about the prospects of enacting an expansion in Virginia in the future, some interest group leaders are looking as far forward as 2021—the year when Virginia’s districts will be re-drawn. Cameron (2015) explains, “2021 is when we have to have everything redistricted with the next census…there’s a lot of effort right now to try to get the process for that to be much less partisan and more based on the demographics.” Yet each year that Virginia waits to expand, the state forfeits billions of dollars while its citizens remain uninsured and its hospitals struggle to provide services to all those in need.

**ARIZONA RESULTS**

**Interest Group Coalition-Building**

Unlike the HAV coalition, the Restoring Arizona coalition was not formally in place prior to the June 2012 NFIB v. Sebelius Supreme Court decision. However, some of the groups that became active players in fight for expansion in Arizona had previously been active in various efforts to support Arizonans in accessing or maintaining health care coverage. For instance, Tara McCollum Plese, Senior Director of External Affairs for the Arizona Alliance for Community Health Centers (AACHC), explains that AACHC and some of its partner organizations started an effort called “Don’t Get Dropped AZ” following the 2011 enrollment freeze of the Arizona Health Care Cost Containment System (AHCCCS, the state’s Medicaid program). This effort was aimed at encouraging as many AHCCCS enrollees as possible to re-enroll in the program in a timely manner in order to avoid losing their coverage as a result of the enrollment freeze. Disappointingly, however, even with these efforts over 250,000 Arizona still lost their health care coverage (Plese 2015).
Once the 2012 Supreme Court decision was announced and Arizona was presented with the chance to opt-into the federal Medicaid expansion program (and receive federal funds to cover 90-100 percent of the expansion costs), health care interest groups shifted their focus to this larger issue. In August of 2012, well before Governor Brewer announced her position on the Medicaid expansion issue, a statewide group of human services providers agreed to hire Chuck Coughlin (President of HighGround Public Affairs Consultants and Chairman of then-Secretary of State Jan Brewer’s Transition Team when she became Governor in 2009) and Peter Burns (President of Burns & Associates and a former state budget director) to create a coalition of hospitals, insurance plans, providers, and other players to push Arizona to expand Medicaid (Reinhart and Sanchez 2012). Both Coughlin and Burns were well known as powerful and experienced actors in Arizona politics. Plesé (2015) explains, “Chuck Coughlin is, for lack of a better way to describe him, he’s a lobbyist and a very powerful lobbyist. He helped get [Governor Brewer] elected in previous offices. He was there basically as one of her primary confidants and that went on.” In an interview with the author, Coughlin emphasizes both the importance of his long, 20-year relationship with Governor Brewer and Burns’ budgetary and health care policy expertise. He states, “We both worked in Governor [Fife] Symington’s administration back in the 90s. Peter I would probably consider to be one of the smartest financial, budgetary health care experts in Arizona. He used to be the state budget director…and was part of the creation of our AHCCCS program here” (Coughlin 2015).

In the fall and winter of 2012, the pro-expansion coalition’s first task was to encourage the governor to come out in favor of expansion. Barbara Meaney, Principal at Triadvocates LLC and lobbyist for Abrazo Health Care (an Arizona branch of national chain Tenet Healthcare),
said the fight to win the governor’s support for expansion was a large lobbying effort on the part of the pro-expansion coalition. Meaney (2015) explains:

I would say that there was a significant effort to talk to Governor Brewer before the State of the State to encourage her to take the position she took. Governor Brewer is, by all accounts, her own woman and that was pretty obvious with the State of the State because really up until right before she gave the State of the State there was no indication of what she was going to do on Medicaid. But there was certainly a fairly intense lobbying effort directly with the governor and her staff to express the importance of this…This wasn’t about Obamacare, this wasn’t about Republicans and Democrats, this was about investing in Arizona’s future. And that was the message that we tried to convey. But you know certainly there was direct contact with the governor on this, there were private phone calls, meetings, and discussions with her staff to provide her information so that she could make her decision about ultimately what she wanted to do.

According to Coughlin (2015), the initial inclination of the Brewer administration was to seek a CMS waiver for the higher federal reimbursement levels to expand coverage to only the population for which Proposition 204 required coverage (the population up to 100 percent FPL). On December 10, 2012, however, Health and Human Services Secretary Kathleen Sebelius announced that HHS would not permit states to receive federal funds for a partial expansion (to cover less than the entire population up through 138 percent FPL) (Centers for Medicare & Medicaid Services 2012). Coughlin views this action (and the timing of this action) as an essential step in Arizona’s road to expansion. He states:

It was important that they came out in the second week of December, I think Sebelius came out in a letter saying you’re either in or you’re out. You’re either gonna cover up to 138 percent or you’re gonna cover nothing. And if they had done that in the middle of January, or later…I’m pretty sure that none of this would have happened. So clarity was a good thing, certainty was a good thing. Because it created a certain policy field where choices were clear.

Coughlin (2015) goes on to describe this point as a critical juncture in Brewer’s debate over whether to support expansion. He explains that when Sebelius announced this ruling, it was a “game changer” that presented Governor Brewer with a “stark policy contrast.” She could either oppose expansion and throw the people who were still hanging on to their AHCCCS
coverage off the program (which would risk casting Republicans as “cold-hearted” less than a year before the 2013 Arizona gubernatorial election), or she could come out in support of expansion to the full 138 percent FPL population.

At this point, Coughlin (2015) explains that the coalition decided to escalate their efforts to pressure the governor to support expansion. He states:

We didn’t want to get ahead of her, but when the [HHS] decision came out we authored an op-ed piece that went in the Arizona Republic from a number of hospital executives out here essentially laying out what we thought the path forward was, which was opt-into the [expansion] program, do an assessment on hospitals to pay for the state’s share of the program, and agree to up it to 138 percent. And we called it Medicaid restoration because, really it was restoring I think 300,000 lives or 280,000 lives which we felt the state was required to restore under Prop. 204. And then expanding it from 100 percent up to 138 percent I think was another 60,000 lives.

As Coughlin describes it, the op-ed piece played a significant role in pushing her towards coming out in support of expansion:

I personally had a phone call with her and her staff when we had submitted a draft of that editorial. We actually sent it to her as we had sent it to the newspaper, and I got a call from her staff and her, and she had many concerns about it. And we talked about it at length one evening in December—I remember the conversation because I was driving home. And she, you know, eventually after much heavy breathing on the phone, I got her to focus on the editorial because she was upset that people were getting ahead of her. She goes, ‘this is my decision.’ I said yeah, absolutely! But these are the health care professionals in the community who have to provide these services to people no matter what…So I explained to her that my client, big groups of clients had a real need to address this issue. And whether she agreed with it or not the policy consequences seemed to be fairly clear. She then began helping us edit an editorial, quite amusing, she wanted some words changed in there and some things changed, and we, of course I said, ‘Well it’s at the paper, I can see if I can get these edits in.’ So she suggested some changes and I, half jokingly but half seriously, at the end of that conversation said ‘Well, now that you've participated in editing the op-ed, I’m sure you're supportive of the policy!’ She did not find the humor in that comment.

According to Coughlin, she “agonized over [the decision] tremendously,” largely because she had run much of her 2010 campaign as opposed to Obamacare and the federalization of health care in general. He recounts how even during the writing/drafting process of her state of
the state address, she had still not made up her mind. Coughlin states, “So we worked on her state of the state address that year, as a group…and you know it was in and out, and it was in and out, and literally nobody knew other than a very, including me, a handful of people before she went and gave the speech that January whether she was committed to it.” However, according to Scott Smith, Chief of Staff to former-Governor Brewer from November 2012 through the end of her term, the governor made the decision to support restoration/expansion weeks before the state of the state speech after recognizing that expansion was essential to the state’s budget and economy. When asked whether the governor went back and forth about the decision leading up to the state of the state address, Smith (2015) states:

She was not clear with external individuals about what she was going to do, or what that decision was going to be. It was a highly politically charged decision, with some pretty severe political consequences. And I can tell you that the framework for the speech was written weeks in advance, and there was only one version of that speech, and to those on the outside it probably appeared like there was some uncertainty around the decision, and I think the governor intentionally played that up because she didn’t want this decision getting out in front of her speech…I can tell you from an internal staff standpoint we fully expected the decision to turn out the way it did, and had it not we would have been absolutely shocked. And again it goes back to the math—had she not gone down that path, we would’ve had to have prepared an entirely different budget to make the state budget work the following fiscal year and we didn’t do that.

The governor publicly announced her support for restoration/expansion in her state of the state speech on January 14, 2013, and this pronouncement triggered public declarations of support from other political actors who would become powerful allies in the campaign for expansion. Representative Heather Carter (2015), Republican member of the Arizona House of Representatives from the 7th Legislative District and Chairperson of the House Health Committee, describes how she came to the conclusion that expansion was the right step for Arizona before the state of the state and publically announced her position as soon as the governor came out in support:
Long before the governor even decided that she was going to advocate for Medicaid, I was doing my homework in November and December because I was Health [Committee] chair, I knew I was going to be health chair, and I said, ‘I better understand this.’ And so in working with staff and doing my research I said, ‘Oh my gosh, this is the only way out of this crisis for Arizona. We better do this!’ I was on board… I was waiting to hear what the governor was going to do, and they said she will not announce until the state of the state. And I said OK, I will just wait until January…I listened to her state of the state and when she said we needed to do this and move forward, I applauded and ran right up to the podium with all the newspapers and I said, ‘This is the right thing, this is the right time, and yes we need to do this.’ That was even before I had even had a conversation with her—I didn’t know what she was going to say in her state of the state.

When asked whether he believes Governor Brewer would have come out in favor of expansion if she did not know that there was already an organized interest group coalition in place to support her, Coughlin (2015) responds, “No. No. She’s not foolish. She wasn’t looking to be a martyr. She wanted to get it done. And she looked at everybody across the table once the hand was played and said, ‘If I’m gonna do this, you’ve gotta be in here with me.’” In response to the same question, Smith (2015) explains:

When she was weighing the options on this issue, she met with representatives from the hospitals around the state and health care leaders from around the state. And in that dialogue she got a commitment from them that if she was going to support the restoration effort, it was her expectation that everybody sitting around that conference table—and you know, it was probably about 15 people representing a number of different organizations—that if we were going down this path, it was incumbent upon all of those in the room to make this their highest priority and do whatever was necessary from a advocacy standpoint to support her on the effort…Those stakeholders and their efforts were incredibly helpful in achieving the successful outcome.

Once the governor came out in favor of restoration/expansion, the “Restoring Arizona” coalition really began to come together and formulate a strong advocacy strategy. The State Chamber of Commerce got more heavily involved in the coalition after the governor announced her position and became a prime organizer and mover of the campaign. According to Smith (2015), Tenet Healthcare Corporation representative Reginald Ballantyne, a member of the Arizona Chamber’s board of directors, was instrumental in rallying the chamber membership to
be supportive of expansion. Garrick Taylor (2015), Senior Vice President of Government Relations and Communications at the Arizona Chamber of Commerce and Industry, explains the pro-expansion stance that the Chamber ultimately chose to take:

The Arizona Chamber was not and is not supportive of the Affordable Care Act. But when you flash forward to the situation the state found itself in, there was an element of the law, and that is the Medicaid expansion, that we felt was important to implement in Arizona, largely for its effect on the state’s budget and its effect on health care providers and their ongoing obligations as it relates to uncompensated care. So in 2013, the expansion of Medicaid…became a major priority and absolutely huge—I don’t think that’s too strong of a word—an absolutely huge campaign that we took on during the 2013 legislative session.

Taylor (2015) later expands on this justification for the Chamber of Commerce’s pro-expansion stance. He first points to the cost-shift of uncompensated care as a primary reason why the Chamber saw expansion as a pro-business policy. He states:

Just because you don’t have a robust Medicaid program or any sort of health care program for the poor doesn’t mean that the need goes away. You just have people who show up in the emergency room that hospitals or the health care provider takes on as charity care, and the cost gets passed on to those of us in the private sector or employers who have health plans, and you know, you’ve just gotta pick up the cost, you have to absorb the cost in other ways.

Taylor then goes on to highlight the fact that the Chamber represents multiple hospital and health care groups, and so many of their own members were very vocal in pushing the Chamber to support restoration/expansion from the outset. He states:

Now keep in mind, the Chamber includes health care interests, such as hospitals. So we also had a membership issue here—we had our own members saying we need to do this. And so after looking at the situation that our health care providers found themselves in, the implications for the state budget, the implications with the law (the voter mandate), we made the decision that ultimately proved to be, well I guess history will determine whether it was the right one, it proved to be a successful one.

Plesse (2015) also describes the enormity of the coalition that came together, stating:

[Governor Brewer] stepped up to the plate and with the State Chamber of Commerce and all the other chamber of commerce organizations throughout the state of Arizona. They rallied the business community while we on the health care side, we worked very closely
with the hospital association, the nurses’ association, and we rallied every health care organization in the state to drive this effort forward. So we basically ended up with a very large coalition, statewide coalition, of businesses and health care interests to work with the governor.

*Interest Group Coalition Composition*

Potentially even more important than the size of the coalition, however, was the composition of the coalition and the coalition’s leadership. Restoring Arizona was not just a coalition of groups that might be seen as “traditional policy allies” (see research design section for definition) in this context. The coalition was led by the State Chamber of Commerce, and it relied heavily on support from more than 20 local chambers of commerce. As Taylor (2015) explains, the business community’s steadfast support gave the coalition greater credibility in its advocacy efforts:

People often put [the Chamber] on the right side of the political spectrum or lean conservative. I suppose that's a fair characterization, but we believe we represent the party of business and we thought that this was a pro-business policy decision that we had lined up behind. And so if anything it gave us credibility, the fact that we are perceived as a center-right group or a conservative group actually gave us credibility because we weighed into this issue and then some people say, ‘Oh, well, Chamber of Commerce, they’re kind of a conservative business group and here they are supportive of the governor's position. Maybe there’s something to this.’ Now I suppose if we were, you know, the coalition to make sure every single person has every dime of health care covered for the rest of their life, well people would have just sort of rolled their eyes and said well of course they’re for this position, there’s nothing unusual about this position. But when the Chamber steps up on an issue it’s like, well ok this is interesting, it’s a broad coalition that’s not supported by just one industry and they’re perceived to be rather conservative so when they weigh in on something it must be for a reason.

When asked about the significance of having the Chamber—a traditionally conservative interest group—leading the effort rather than one of the many other involved groups, Smith (2015) explains, “I think that was incredibly beneficial in Arizona…The Chamber was, you know, their involvement was incredibly instrumental in helping achieve the outcome…I mean
representative thomas “t.j.” shope (2015), a republican member of the arizona house of representatives from the 8th legislative district (and one of the 14 republican legislators who voted for restoration/expansion), also emphasizes the importance of the chamber of commerce’s role in the campaign in solidifying support for expansion from conservative legislators. he states:

restoring arizona…that was the front name given to the group that the arizona chamber of commerce and the arizona hospital association kind of put together, and they were very influential. arizona was able to do it because they had groups that are traditionally republican, you know, back republicans and back conservative causes, that decided to get behind this. in my understanding, that was kind of a unique situation across the country, and i truly believe it was one of the reasons why [expansion] ended up passing.

representative shope (2015) then goes on to describe the influence of conservative groups like the chamber in his own personal decision to vote for expansion. he explains:

one of the questions you’re often asked is, ‘where do you label yourself as a republican?’ or if you’re a democrat, ‘are you progressive? are you a union democrat? what are you?’ for me, i’ve always been unabashed, like look, i’m just a chamber of commerce-type republican, and that used to be very much the majority back in the day. and now, obviously with the rise of the tea party and such like that, it’s kind of a battle for the soul of the party. but [in choosing to support restoration/expansion] i really didn’t view myself as going outside of what my parameters, of what i had told people i was.

while led by the chamber of commerce and the arizona hospital and healthcare association (azhha), the coalition as a whole was much more broad-based and included many non-business groups (many of whom were heavily involved in the grassroots campaign and other aspects of the advocacy strategy). supporters named on the restoring arizona website include doctors’ and nurses’ alliances, hospitals and community health centers, health plans/insurers, disease-specific groups (e.g. the american stroke association, the arizona autism coalition, and the arizona hemophilia association), multiple indian tribes from across the state, and a
variety of other public interest-oriented groups (e.g. the People of Color Network, the Pima Community Access Program, Sexual Health Experts, and the Arizona Coalition Against Domestic Violence) (see appendix for full listing of Restoring Arizona Supporters) (restoringarizona.com).

Another aspect of the coalition composition that is important to recognize is the fact that Planned Parenthood was not involved or on Restoring Arizona’s list of supporters. When asked about why Planned Parenthood, a vocal supporter of expansion in many states (including Virginia) was kept away from Restoring Arizona, Smith (2015) explains:

When we’re trying to achieve a certain outcome from an incredibly conservative legislature, it would not have been helpful to have Planned Parenthood as a named supporter or contributor to the effort. And that may have been a conscious decision at some point along the way by somebody—I don’t remember enough to tell you whether that was the case or not, but that doesn’t surprise me. You know, that organization has a stigma associated with it for conservative lawmakers, so I could totally see them intentionally being left out.

Taylor (2015) offers a similar explanation for Planned Parenthood’s separation from the campaign, stating:

I think you would have seen a similar scenario if a group with, you know I don’t think I’m saying anything out of school here, that comes with the level of controversy that Planned Parenthood has. I think people would get very suspicious and they would say, ‘Wow, wait a second, I’m on the same side as Planned Parenthood on this?’ I don’t think it would have helped. I think it really would have taken—it would not have helped.

Representative Shope (2015) explains that a major consideration in his decision was the policy’s implications for socially conservative values on issues like abortion. He states:

I’m probably the most socially conservative member that voted for it. So there was a lot of talk about abortion funding and things like that. After a long conversation with my district from the, from the Diocese of Tucson, we came to the conclusion that was, I think the catholic groups, for me were pretty instrumental in getting me to sign on to it…[The Catholic diocese] were very much in favor from the beginning…the abortion question was settled to my satisfaction, and obviously to the bishop’s satisfaction. So that made it a lot clearer for me…It made business sense on one end, and then I was able to justify it in the social sense as well.
Active involvement by a group like Planned Parenthood, therefore, seems like it could have potentially counteracted the efforts of these Catholic groups and made the justification of expansion from a socially conservative perspective more difficult.

Financial Investment in the Coalition

Many interest groups involved in Restoring Arizona made substantial donations to the coalition. This funding, which was put into a fund organized by the Arizona Chamber of Commerce (Whitney 2015), became essential to the execution of the large-scale, multi-faceted campaign. According to the Restoring Arizona website, major funding for the coalition was provided by four groups: the Arizona Business Coalition, AzHHA, Stand for Children Arizona, and the John C. Lincoln Hospital (restoringarizona.com), yet a large number of other supporting organizations made significant contributions as well. These contributions primarily went into a Chamber of Commerce fund that was used to finance the massive advocacy campaign. Meaney (2015) explains:

There were definitely financial resources that were brought there by the health care community, by hospitals, by other providers to move the effort forward. I mean there was a pretty significant social media grassroots campaign with advertising, there were mail pieces, so you know, that requires financial investments and Abrazo did participate in that.

According to Helena Whitney, Director of Government Relations and Legislative Affairs at the University of Arizona Health Network, that the high degree of coordination in the Restoring Arizona effort allowed the campaign to use its funds more efficiently and effectively. She explains:

I think…that the coordinated effort made it much more effective than it would have been otherwise…I think the money that was spent during this process was spent in a more effective manner…it’s actually the only time I think I’ve ever been involved in a process that was as coordinated. And it wasn’t easy, you know, a lot of calves to herd, but having a central place where everything sort of went through actually made it a lot easier. People
were a lot more consistent in their messaging. I do think it made the process better and more effective (2015).

When asked whether a lack of funding ever prevented the coalition from organizing or executing pro-expansion initiatives, Plese (2015) responded, “No, the funding never was lacking. Everybody stepped up because they were so concerned about what would happen in the future if we continued on the same path that we were on.”

Coordination of Restoring Arizona and the Pro-Expansion Campaign

Restoring Arizona was not only a large coalition composed of a wide range of interest groups. It was also impeccably well organized and coordinated in its pro-expansion advocacy efforts. This coordination largely came from the leadership of the governor’s office and the Arizona Chamber of Commerce.

Taylor (2015) explains that before the Chamber took on a leadership role in Restoring Arizona, the business community was generally supportive of restoration but their support was too bifurcated—individual groups would come out in favor of restoration/expansion but the groups had not “quite congealed into a real coalition.” According to Taylor, the Chamber became the “prime mover” of the Restoring Arizona campaign when it took on a leadership role in late January or early February of 2013. He states:

It didn’t feel like a real campaign until [the Chamber] started to run it like a campaign. And we capped a, somebody to serve as sort of the campaign chairman/manager, a gentleman named Jaime Molera. And Jaime began to really get people to organize around one, sort of, objective goal here. And then internally we had our own sort of campaign manager who was really kind of running behind the scenes for Jaime, and her name is Brittney Kaufmann, and Brittney took her campaign experience and put it to work on this issue. And so it was being run from that point like a real campaign, including a fairly sophisticated social media strategy, including Facebook, Twitter, websites, TV ads, radio ads…I mean this was full-on campaign mode. And if you think about it, we weren’t trying to convince voters, we were trying to convince legislators and we were hoping to get to their constituents so the constituents would tell their elected official where they were.
Plese (2015) confirms the Chamber’s role as a lead coordinator of the Restoring Arizona interest group effort:

I would say that actually the driving force, the group that was collecting the money and making sure that the groups that were working on this were operating in lockstep and that everybody was moving in the same direction…would be the Arizona Chamber of Commerce…And a gentleman named Jaime Molera, who was the former superintendent of schools and has his own lobbying firm, and so his firm did a lot of the strategic work. And a lot of the fundraising and organizational things actually came out of the State Chamber. And then the rest of us were doing our own part with our own patient populations and our constituents.

Describing the collaboration between and responsibilities of the Governor’s office and the State Chamber, Smith (2015) explains:

It was an entirely collaborative effort, and, you know, we all worked in partnership. The legislative effort was run primarily out of the governor's office, the external affairs effort was handled by Brittney and Jaime, and so we were essentially teammates. And the Restoring Arizona effort was incredibly instrumental in rallying those constituencies outside of the capitol. And they were also helpful lobbying members obviously, and that was part of their focus, but they were really responsible for going out and generating support from countless other business groups and associations and entities that would have been impacted had this measure not been successful.

According to Coughlin (2015), at the weekly Friday morning Restoring Arizona coalition meetings at the governor’s office, the governor and Smith, the governor’s chief of staff, handed out assignments to individual interest groups/interest group leaders. Johnston explains, “[The weekly meetings] were chaired by her staff, and we had debriefings on who met with which legislator that week, the previous week…what were the responses, who needed to follow up.” Coughlin also emphasizes that there was a great deal of coordination on this policy across the executive branch (between multiple advisors in the governor’s office, leaders at the AHCCCS agency, and leaders at the Department of Health Services).

As chairperson of the House Health Committee and the primary leader of the pro-expansion advocacy efforts in the Arizona House of Representatives, Representative Carter
(2015) was highly involved in the coalition and the coordination meetings as well. When asked how she coordinated her advocacy efforts with the governor and the Restoring Arizona coalition, Representative Carter explains:

As we started to build the coalition around who was going to support this or not support this, the governor would bring members to her office, she made her staff available to answer questions, and we were all kind of on-call for each other as a true team throughout the process. There were many times when people would say, ‘I’m not so sure about this,’ and we needed to be able to answer questions in a timely manner. If they were going to a town hall and they needed support to explain the policy with constituents, we provided support for constituents so that they could have that information to share with them. We had regular meetings…we met on a regular basis. We stayed in constant communication throughout the entire process.

Given that Restoring Arizona was such a large coalition, not all of the coalition supporters could be present at the weekly meetings at the governor’s office. Yet the coalition was adept at ensuring that Restoring Arizona strategies and initiatives were communicated effectively with these smaller or more distant interest groups.

Part of the Arizona Chamber’s role involved communicating with over 20 local chambers of commerce and additional local-level business groups, ensuring that they were operating in line with the Restoring Arizona strategy. Taylor (2015) explains:

If you were part of the so-called Restoring Arizona team I think you’re at the table but if you were a business group, say in rural Arizona, you were getting reports from maybe the greater Phoenix Chamber, maybe the State Chamber. There’s…an organization here called the Arizona Chamber Executives, and that’s helpful for people who aren’t in the greater Phoenix area to keep up with what’s going on politically.

When asked whether all of the interest group initiatives (even those of the smaller groups) were coordinated through Restoring Arizona (as opposed to being conducted completely independently from the coalition), Debbie Johnston, Senior Vice President of Policy Development at the Arizona Hospital and Healthcare Association (AzHHA), responds:

So I think there were some organizations that were not necessarily part of, I want to say, that core sort of group that met in the governor’s office…so I would say not every single
provider organization or advocacy group was up there Friday mornings. But the coalition was I think much broader than that, and so I think most of the folks who were proponents of Medicaid expansion had some sort of relationship with the coalition. But there was probably a core group that really kind of got assignments, and it was mostly, you know, really the provider groups and the business groups. And some of, like the heart association, I mean some of those patient advocacy groups as well were up there also (2015).

Taylor goes on to emphasize social media’s role in facilitating the lines of communication between central and more peripheral groups:

I talked about not over estimating the effect of social media campaigns, but also let’s not underestimate it because what a great way to get out to social media and say, ‘Alright guys, look: This is a big week for us, it’s really come together and if you’re meeting with your local legislator then let them know what’s going on.’ It’s that kind of stuff, so that’s where I think the campaign played a good role—just because you weren’t in the leadership meetings or sitting there plotting strategy doesn’t mean that you didn’t have an active role to play.

Another aspect of the Restoring Arizona campaign that required enormous coordination was negotiating and retaining support for the hospital assessment funding mechanism to pay the state’s share of the expansion costs (described in greater detail in the Arizona background section). Describing the general hospital perspective on the assessment, Plese (2015) states:

The hospitals…stepped forward and said we will do an assessment—it's not a tax, it's not a financial burden for our patients, we as hospitals will pool our funding and we will do that. And part of that reason was because we had seen such large numbers of uninsured people coming to their doors, and their uncompensated care had gone up dramatically, as had the community health centers’ and other providers’ who serve Medicaid patients. So statewide we were seeing this as a real fiscal crisis to the health care community. So...the hospitals [stepped] up and [said]...we will take on the assessment and we will make up that matching fund because, in the end, it will be more profitable for us to do this and to get those [federal] matching funds than to continue to provide uncompensated care.

Additionally, Plese (2015) explains that several of the state's hospitals' and health care systems' prior experiences implementing safety net care pools helped them see the benefit of the assessment. She states, “So now you have these two safety net pools running, and it was working
well for them. So that’s really why those hospitals said, ‘We’ve had this experience, we know that it’s working well, so we’re willing to continue this as a statewide hospital assessment.”’

While Johnston (2015) agrees that overall hospitals were supportive of the assessment, she says that they did have some significant concerns about how the mechanism would work. A major concern centered on the strict federal rules regarding provider assessments. According to Johnston, federal rules require that how the fee is assessed on providers must be balanced out with how the money is redistributed. Essentially, states are not allowed to levy higher taxes on providers that do more Medicaid business—the taxes have to be evenly distributed between providers (and this is measured through a specific statistical test). Under the assessment model proposed by Governor Brewer, the revenues collected via the assessment would go to fund restoration and expansion, and the AHCCCS director would be given the authority to develop the specifics of the assessment model. Johnston (2015) explains:

There was a lot of trepidation and uncertainty around this financing mechanism within the hospital community. But as a matter of policy, our members believed that it was the right thing to do. So we kind of, you know, we sort of held our noses along with it. We had a board meeting and basically the board…met and they did agree to support the proposal including the assessment, but with the caveat that the assessment should be done in such a way that no hospital would lose—basically would pay out more than they’ve recovered in new payments…We left it up to the AHCCCS agency to actually come up with the model as long as they agreed with that principle of ours. And at the end of the day they did.

However, keeping the hospitals united in support for the assessment was a difficult task that fell largely on AzHHA. Johnston (2015) emphasizes the magnitude of this undertaking, stating:

Within this whole context we had to keep our members together because of the assessment. Because there was trepidation about how this assessment would look, and whether anyone actually would get hurt by it…Obviously Medicaid in Arizona, like a lot of other states, it doesn’t pay cost—[Arizona] hospitals get about 70 cents on the dollar. So while it was a benefit to the hospitals because we would be reducing our uncompensated care…you’re bringing in patients, potentially, into the hospital where you
know you’re not gonna be recovering your full costs. But at least you’re getting paid something. But we did have hospitals that were worried about those underpayments and how that was gonna pencil out for them in the end.

AzHHA, therefore, had to work extremely hard to hold its members together in support of the assessment-based expansion plan and reassure members that the Association would “have their backs” in the negotiations with AHCCCS. This essential piece of the Restoring Arizona puzzle was a primary responsibility of AzHHA, and something that other provider groups and the Chamber did not have to worry about.

Looking back on Restoring Arizona’s coordinated campaign as a whole, Smith (2015) expresses amazement at the incredibly well coordinated campaign that was executed:

In my memory, and I’ve got 20 plus years around the state legislature, this was by far the most organized, collaborative, and executed policy objective I’ve ever seen put into motion. I mean essentially this, the whole effort was run like a, almost like a, or not almost, it was run like a campaign for governor. It was a full-fledged, multi-pronged approach battling the legislature while campaigning externally around the state to get the message out about the importance of this issue. And you know, it impacted across all of Arizona, whether it’s the safety net hospitals in Phoenix and Tucson, or the livelihood of Arizona's rural hospital network. Without the federal dollars you would have had some rural hospitals closing, and when it came time to deliver a baby you're hopping in your car driving a hundred miles to get to the delivery room.

Coughlin (2015) seconds this sentiment, stating, “I don’t think it would have been successful without that coordinated effort,” and Taylor (2015) adds:

I really think that this could be a book, or at least an e-book…because it was just such an unusual situation, and yet was run with such effectiveness and success. And I think if you had been dropped here from a planet and said, ‘Oh, uh, this is a conservative Republican governor and she’s going to try to expand a health care program that will be accused of being Obamacare,’ you’d say that that’s just not going to happen. And yet it did. It happened.

**Messaging and Primary Arguments**

The Restoring Arizona coalition also executed an exceptionally well-coordinated and effective messaging and public relations strategy. However, framing expansion in an appealing
manner was in many ways a more difficult task for expansion proponents than making expansion sound unappealing was for opponents. Taylor (2015) explains:

Now the opposition…said that Governor Brewer was…inviting Obamacare into Arizona, she was implementing Obamacare in Arizona. Now that makes for an excellent talking point…so the other side had a much better bumper sticker than we did. Because, you know, ‘The governor is supporting Obamacare.’ And what does our bumper sticker say? ‘Well, no, because it’s really more complicated than that…’ I mean come on, you can’t. So we really had our work cut out for us.

In order to overcome these strong anti-expansion messages, the coalition invested in numerous public opinion polls to inform its messaging strategy. Clearly articulating the importance of polling for the overall pro-expansion campaign, Whitney (2015) states:

Essentially, doing the polling is what made crafting the messages that we used, and then being able to augment them based on the audience we were talking to, a lot easier…It takes all of the guesswork out of trying to figure out what it is that people care about…It’s a key component of understanding how to move policies forward. And, you know, not a lot of people do it unfortunately. Sometimes I think that the policies just don’t go anywhere because we don’t know how to talk about them in a way that people will hear it. We tend to talk about what we want to talk about but not really about what people want to hear. So that, for me, is a big thing.

Coughlin (2015) describes how polling was used even before the governor’s 2013 state of the state announcement of support—polling results largely instigated the framing of the initiative as about “restoration” rather than “expansion.” Coughlin states:

So we called it restoration, we branded it as restoration, we tested it in public opinion polls and we found, amongst high-efficacy voters, we found that a Republican audience when they understood the issue…were split about 50-50. Fifty in, 50 out. Democrats were overwhelmingly supportive, independents similarly to Republicans but a little bit better. PNDs, which are Party Not Disclosed (which is actually a bigger portion of the electorate than most people think) were almost identical to Democrats. So the overwhelming public opinion majority of high-efficacy voters, which we anticipated to turn out in the next general election cycle, we could show through our polling data were overwhelmingly supportive of restoration and expansion. And we did survey work to that effect, we showed the Republican split to every policymaker we could show, but we also showed all of the overwhelming numbers on the other side of the equation, on the other partisan groups.
Plese (2015) also stresses the importance of framing the initiative as a restoration of the coverage for the population up through 100 percent FPL that the voters mandated in Proposition 204—the coverage that many had lost after the 2011 AHCCCS enrollment freeze. Plese explains:

We were always very careful to say this was a restoration, and expansion, but really emphasize the restoration. And that’s why it was called “Restoring Arizona”…This is a very conservative state, and as such, the idea that we were basically restoring something that the voters had voted on twice, that it really was more of a restoration, we weren’t creating a new federal program, really was much more appealing even to those moderate Republicans than if we had said, ‘Oh, yeah! We’re gonna take on…Obamacare, and we’re gonna do an expansion!

As Restoring Arizona put it, opting-in to the federal ACA expansion program was really about getting the federal funds that the state needed in order to finance the restoration of coverage for the population below 100 percent FPL. The expansion of coverage for people between 100 percent FPL and 138 percent was almost a side effect—a necessary (yet secondary) step in the process of implementing a restoration.

Describing additional specific polling results that Restoring Arizona leaders used in advocacy/messaging efforts throughout the campaign, Johnston (2015) states:

Republican women do support this program—they support the restoration of Prop. 204…The term “AHCCCS,” which is the name for our Medicaid agency, it actually polls pretty well compared to “Medicaid.” And Prop. 204, you know believe it or not people around here kind of know that term, and when you remind them that it’s voter approved that polls very well. So there were some of those words that we were able to use.

The Restoring Arizona advocacy strategy relied on consistent use of the coalition’s central talking points by all interest groups and leaders involved in the coalition. According to Taylor (2015), the talking points used by the business community were very similar (and often the same) as the talking points used by other non-business groups active in Restoring Arizona. Meaney (2015) describes the effort that went into emphasizing the economic and business benefits in the coalition’s talking points and overall messaging strategy:
Arizona really made this not so much a hospital issue, but a business community issue. So hospitals are 20 percent of the economy in Arizona, they are one of the huge segments of the economy that was continuing to grow. The matching federal dollars give a significant return on the investment, if you will, so the business chamber was really kind of front and center in moving the message forward, and of course the hospitals significantly supported the effort. So we really tried to put it more in economic terms rather than more of social well-being terms about helping people who need health care choices…the kind of dollars-intense arguments resonated a lot more in Arizona.

Johnston (2015) describes the specifics of some of the economic-based arguments that the coalition put forth:

We also talked about the contribution that health care makes to the economy, you know a large portion of the economy. We talked about the cost shift—that when hospitals lose money off of uncompensated care, there’s no free lunch. It’s not like eat the magic beans and that uncompensated care just gets absorbed. Somehow it gets passed on, whether it gets passed on through cost shifting to commercial payers, or whether you need to reduce staff or reduce services, something’s going to have to give.

Coughlin adds another key element of the financial-based argument—the coalition compared the AHCCCS program to other states’ programs and lauded it for its fiscal conservatism. They hoped that by speaking to the efficiencies of AHCCCS (and bringing forward some of the founders of the AHCCCS program, such as a well-esteemed former Senate president, to convey the message), the coalition would be able to weaken the connection between restoration in Arizona and the intrusion of liberal federal health care programs into the conservative state.

Representative Carter (2015) also emphasizes the importance of adapting the messaging approach to the state-specific context. She explains:

Every state is completely unique. In conservative states, you’ve gotta give a business solution, you’ve gotta show why it makes financial sense, and you’ve gotta show why having better health outcomes and a robust health care system is good for, you know, conservative beliefs and frame it from that perspective. So you’ve gotta consider who your audience is—just because one argument works in Arizona it may not work somewhere else.
Putting a New Face on the Coverage-Gap Population

Another goal of the Restoring Arizona messaging strategy was to change the face of the coverage-gap population. Explaining the reasoning behind this strategy, Johnston states:

When you see a hard working person who is not some typical, the stereotype that some people have in mind of a Medicaid beneficiary—someone who might be addicted to drugs, you know, lives on the street, if they were more responsible for their own care they wouldn’t need Medicaid. When you can show [expansion skeptics/opponents] someone else that doesn’t fit that stereotype, their hearts can kind of open up.

Arizona interest groups (like groups in Virginia) tried to illustrate the fact that a large number of veterans are included in the coverage gap population. Johnston (2015) explains, “We started to look at some other impacted groups, so veterans. We found one veteran, a childless adult veteran, who was in a motorcycle accident…So that was another talking point that works for Republicans sometimes—when you start putting different faces on this population, and the veteran was one population that we could put on it.”

Coughlin (2015) explains that focusing public attention on the mental health care benefits of restoration/expansion was another strategy that proved very effective for Restoring Arizona. Smith (2015) asserts that Restoring Arizona did not make any intentional efforts to directly link the attempted assassination of Arizona Congressional Representative Gabby Giffords to the mental health care benefits of restoration/expansion. In the wake of the shooting, however, Coughlin suggests that the mental health benefit message platform may have resonated especially powerfully with Arizonans. Coughlin states:

A lot of people believed the Gabby Giffords shooting down at Tucson was related to mental health programs, and the state was falling short on its ability to provide care and services for the seriously mentally ill, which was another enormous personal concern of the governor’s historically. She had been involved in that from the time she became a legislator, and so we talked a lot about the mental health care provisions in the bill, and what that would mean to the SMI population, and how important that was to public safety. We got police, you know unions, police chiefs associations talking about how important it was for health care and for mental health care for these populations and how
that would reduce violence and provide a more stable platform for people to grow and have opportunity, even in the down economy. And so we were hitting on all kinds of message platforms which we thought would assist in covering those Republican legislators that were supportive of the program.

While convincing patients to come forward publicly with their medical experiences was difficult, according to Johnston (2015), the coalition was able to acquire several powerful stories for use in the 2013 restoration/expansion campaign. She explains both the challenge and importance of using patient stories in the pro-expansion campaign:

Patient stories is the hardest piece of this because, you know, you can talk about uncompensated care, you can talk about the economy, you can talk about all sorts of, you know it’s the right thing to do for patients…you can have how many cancer patients have lost coverage, but having those patient stories out there and having patients that Republican legislators can find sympathetic, you know is a little, it can be challenging…a lot of people do not want to talk about their health care experiences…people can be proud and they don't necessarily want their neighbors to know that they’re on Medicaid, and so it can be hard at times…We tried to identify patients that were willing to come forward to really tell their story and why this was important… It’s hard to sell this to the electorate until they really can put kind of a face to this.

Johnston goes on to describe a few of the patients who were convinced to come forward and tell their stories to the public:

That face can be a young woman who’s in her 20s, she’s timed out of her parents’ coverage but she has, maybe, cystic fibrosis, and she’s trying to work but she can't work full time because of her condition. It’s not her fault that she has this disease, but this is a typical childless adult. And she doesn't have her own insurance coverage, she works part time but she doesn't make enough to purchase insurance, and she works, you know, the one woman that did come forward with this, I mean she did have cystic fibrosis, and she was, you know, an assistant coach at a catholic high school.

…There was another patient, she was a student at ASU, and she had—I can’t remember what the condition is but it was some sort of eye condition, and without her medication she could go blind, and she’s a full time student really trying to—I think she had been maybe in foster care or something, but she had timed out and she had no other source of insurance. And so making sure that she had health care while she was in school—you know her goal was to get a good job, to get insurance, and to get off Medicaid. But in the meantime she needed this so that she wouldn’t go blind.

…We had another couple in their, I want to say in their late 50s, who…lost their insurance…I think because maybe the husband had a stroke or something happened…and
they were too early for Medicare, but obviously they didn't have any dependent children, so they didn't qualify…But you know, worked all their lives, outstanding citizens, that type of stuff.

While Johnston (2015) says that Restoring Arizona could always have used more stories, she believes that the ones they were able to use were effective in strengthening the coalition’s message. She explains, “So I think we had some good core [stories], but as I said they’re hard to come by. I think one of the toughest pieces for [AzHHA] was everyone said go get patient stories, and we had to work really hard to get the ones we did.”

**Lobbying Legislators Directly**

Smith (2015) is uncertain about the extent to which the Restoring Arizona approach to lobbying legislators was successful. Part of the strategy involved reaching out to encourage the support of Precinct Committeemen—individuals who are elected in each legislative district in Arizona and have the responsibility of helping fellow members of their political party to vote. However, Smith explains:

I think when we started out, we were optimistic that the dollars and cents approach with this would be enough to carry the day with the majority of Republican lawmakers. We went to great lengths to educate political interests and political organizations about the importance of this issue for Arizona as a whole, you know, to include precinct committeemen and legislative district chairmen, you know, other political entry-level or lower level political opinion leaders in an effort to give them the facts so that they would understand the basis for the decision, and then hoping that having an open dialogue with them would be helpful. In retrospect, that effort probably backfired on us and, in part, caused the intensity of the issue to ratchet up at the local level, which in turn drove those precinct committeemen and district chairmen to drive their lawmakers even further away and become more entrenched on the issue…When you sat down and analyzed this impartially without the political lens, there was no other decision that could have possibly been made, and we thought that the logic and the math would win out with the majority of Republicans. But that just ended up not being the case.

Interestingly, Smith (2015) explains that if he had the opportunity to go back in time, he would expedite the legislative process and drastically shorten the time for debate over restoration/expansion. He states:
If I had to do it all over again I would have recommended that the governor immediately call for a special session in her state of the state speech, and had immediately commenced a special session to get the bill introduced and through the process sooner rather than later. You know, our efforts to try to cultivate people in the opposition caused the process to drag out longer and longer and longer, caused people to get more entrenched, and we thought by, again, having a lot of communication and an open dialogue that people ultimately would come to their senses. But it had just the opposite effect. So we probably would have been better off just immediately calling for a special session and trying to force it through on the front end, and possibly could have had more success and could have been less acrimonious. At least that’s some of the Monday-morning quarterbacking I’ve received from various folks over the last couple of years.

When asked whether he agrees with the idea that calling for a special session and trying to push the bill through earlier would have been a better approach, Representative Shope (2015) states, “We didn’t actually act on it ‘til June—all that did was prolong the agony…Perhaps if we had just gone ahead and done it right away, maybe we wouldn’t have had the problem. I don’t know, I think that the extension of time on this single issue allowed the camps to definitely become entrenched in their ideas, so maybe that’s right.” However, when asked if he thinks enough legislators would have been supportive of restoration to get it passed earlier in the 2013 session or during a special session, Representative Shope says that he is not sure. He explains that he probably still would have favored it, but says, “I don’t know, it’s hard to say if we would have gotten any more or less votes than we did.”

It seems that part of Smith’s (2015) perspective here is a result of political consequences that he and other pro-expansion individuals faced as a result of the drawn-out battle. He explains:

It was an incredibly intense period and there were some folks, including myself, that still have damaged relationships as a result of that effort. The opposition tried to paint it as an expansion of Obamacare when, you know, the fact of the matter is Medicaid existed long before anybody even thought of Obamacare, or long before Hillary Clinton ever talked about universal health care…it was unfortunate that the Medicaid components of the Affordable Care Act allowed the opposition to draw that connection (2015).

Representative Shope (2015) also describes how the divisive battle over restoration took a toll on relationships (especially those within the legislature). He states, “The animosity was
tough because everybody knew what the elephant in the room was, and it made it difficult to have relationships with the leadership...things like that. It was kind of paralyzing.”

In contrast to the viewpoint expressed by Smith and Representative Shope, however, other Restoring Arizona leaders suggest that much of the lobbying strategy directed at legislators was effective. According to Meaney (2015), the education component of the direct lobbying strategy was successful. She explains:

I’m hard pressed to think of another effort where there was as much education and delivery of materials and explanation and really engagement from the legislative body to truly understand the issue. So I think from that standpoint, that’s probably about as good as it gets. So I do think that the legislature really stepped up and really did learn an awful lot about how that funding works. And so certainly while not as granular as people in the field, I think in terms of big picture issues and understanding the financial impact to the state, yes there was definitely a successful effort on that front.

Tactically, the strategy for lobbying legislators had multiple components. According to Coughlin (2015), the primary focus of the campaign was to maintain support from legislators who came out in favor of expansion, and prevent the opposition from gaining ground in that constituency. He explains, “Our goal was to speak to the constituencies that we knew were supportive of the plan and to message to those constituencies continually and not let the tail of the opposition wag the dog of the supportive community.”

According to Plese (2015), keeping the Democrats united in support of restoration/expansion was a more difficult task than one might expect. She explains:

On the Democrat side, that actually took some heavy lifting on their side to make sure they kept their coalition together. Because they had a few people in that Democrat coalition who were ‘pro-life people’ who were told that the Medicaid expansion would…free up more [Planned Parenthood] money for abortions…So the pro-life Democrats were very cognizant of that, and it took a lot of heavy lifting from the Democratic leadership to make sure they stayed on this.

Coughlin also highlights another element of the challenge of maintaining unity within the Democratic caucus. He recounts that initially, there was concern that Democrats might try to
expand the program further (for instance, covering additional services) rather than fully embracing the governor’s plan. He states:

I have to give credit to Democratic leadership…their restraint in understanding the risk that the governor was taking politically was laudable. They maintained message discipline within their caucus—[Democrats] were as disciplined as policymakers as the Republicans who were supportive of it were. They all spoke to the same points…and talked about restoration, talked about Prop. 204, talked about fiscal consequences to the state, talked about the mental health care community, talked about the fiscal responsibility, the fiscal conservatism of a program like AHCCCS…It was quite a political balancing act. But it was done.

The other side of the tactical lobbying strategy involved working within the Republican caucus. Coughlin (2015) explains his belief that the coalition was successful in isolating some of the opposition and limiting their ability to gain ground:

I went over to the state party executive committee meeting with the governor’s budget director and made a presentation to what I would call the “belly of the beast.” It was not well received, but we decided we owed it to them to let them hear what the thinking was. And I think that was very helpful in isolating that opposition—it sort of neutralized some of the passion…and sort of created a focus on the most radical fringe elements in the Republican party who were most vocal about…their opposition…It was not easy, but we went out and engaged the debate…So we had a very robust grassroots effort to engage those folks…the theory on that was to limit the ability to gain any ground, so isolate them.

A major challenge of this side of the strategy, however, was to avoid making restoration/expansion an even more polarized, partisan issue. As Meaney (2015) explains, “You don’t want to brand it as a Democrat issue, you don’t want to brand it one way or the other.” A significant component of the lobbying strategy, therefore, directly focused on having the push for expansion come from within the Republican Party. Rather than relying on Democrats and liberal interest groups to do all of the lobbying, there was a strategic effort to encourage Republican supporters of restoration/expansion to speak with their colleagues and attempt to persuade them to back it as well. Coughlin (2015) explains:
Both houses of the overall chamber were controlled by Republicans, we did not have a majority of Republicans in either chamber that supported restoration…And so it took an extraordinary amount of courage for [Republican legislators] to work in those caucuses. Because it was brutal hand-to-hand intellectual combat with other members who were, you know, the majority of Republicans were adamantly opposed to the Affordable Health Care Act, and any portion thereof, and refused to adopt any portion of it.

As the lead coordinator of the advocacy effort in the House, Representative Carter (2015) (a Republican) explains that her lobbying approach focused on adapting the case for restoration/expansion to individual legislators’ concerns. She states:

Opposition was primarily based on ideology, just beliefs that the Affordable Care Act was 100 percent wrong…So I tried to work with members to see what was important to them, like what they believed, what they were basing their decisions on. Were they basing it on a financial decision? Were they basing it on a human rights position? And then I tried to explain, using whatever their framework was, why this was a good idea.

Looking back on the bipartisan lobbying effort, Meaney (2015) states, “What I thought was really wonderful about the adoption of the bill was that for a brief moment in time, it was really a collaborative effort. It was Republicans and Democrats working together in the trenches to get this done, and that’s not something that is always visible in politics, so that was a positive.”

This work on the part of Republican legislators, however, came with enormous political risk. Representative Carter explains that some legislators were unwilling to vote for restoration (not to mention openly advocate for it) because of the threat of opposition from the conservative base. She states:

I even had some members tell me this, behind closed doors, and their names shall remain nameless: ‘Heather, you’re doing the right thing. I’m glad that you guys have stepped up to do this, [that you have] done this, because it does solve this huge financial crisis. But politically, I don’t want to take the hit from my base, from my grassroots.’ More than one person said that, ‘It’s the right thing to do but I just couldn’t do it because I don’t want to deal with the political fight I’m going to have to go through.’
Many of those involved in Restoring Arizona emphasize that several conservative interest groups threatened to target any Republican legislators who came out in favor of expansion in their reelection efforts. Meaney (2015) explains:

There were high stakes involved for a lot of those Republicans who supported the Medicaid restoration and expansion program. There was a lot of concern that they would lose their reelection. There were a lot of conservative interest groups fairly blatantly discussing how they would be targeted in their reelection efforts, and that anyone who had supported the governor’s plan would not be back in the legislature.

After expansion passed, the Governor and some of the interest groups involved in Restoring Arizona were active in supporting these Republican governors to ensure that their vote for restoration did not cost them their seat. Smith (2015) explains, “I think [Governor Brewer] recognized that their support of Medicaid made them vulnerable, and she recognized the value that they bring to the legislature and the importance of their votes, and so she wanted to make sure that the opposition were not able to drum them out of the legislature over that particular issue.”

In order to do this, the Governor formed the Arizona’s Legacy PAC for the purpose of helping those Republicans who broke ranks on Medicaid. By February 2014, Arizona’s Legacy was the best-funded independent political action committee in the state (AzHHA and the Arizona Business Coalition, a group formed by the state chamber, were both among the top donors). Governor Brewer also used funds from Jan PAC, her federal political action committee which raised $272,000 in 2013 alone (Fischer 2014), to provide political help to the individuals she called Arizona’s “health care heroes.”

While this support played a major role in allowing these legislators to stave off the intense opposition in their 2014 reelection campaigns, it does not appear to have swayed legislators’ decisions on whether to vote for expansion. Representative Carter (2015) explains:
There was nobody that would have otherwise not supported it…so it wasn’t really about this whole, ‘If you support this we’re going to support your campaign.’ Because that’s illegal…The commitment was, ‘We’re in this because we believe it’s a good policy. Now if you believe it’s the best policy as well, we’re all in this together.’ Not ‘Will you vote for this because I’m going to give you campaign money,’ because that’s downright illegal. But that is sure the way the opposition spins it…But when you campaign and you raise money, you raise money from the people that support the policies—just like the people that were opposed did, they raised money from the big money donors that were opposed to it. Because the people that support, you know, your body of work are going to support you. The people that don’t, don’t.

Smith (2015) concurs, explaining that he thinks the legislators welcomed the aid on the campaign trail but does not believe that any sort of pledge to provide political support was what persuaded any of the Republicans to take a pro-expansion stance. Smith states:

The Republicans who voted in favor of the Medicaid restoration effort did so because they were in agreement with the governor’s analysis and decision, and I think every single one of them on the Republican side would have made that vote regardless of whether or not the governor was interested in helping them in their election efforts…Lots of them were from rural Arizona and they knew that their local hospitals were in trouble. They also were willing to do the type of analysis and practical decision making that needed to be done with this issue.

Coughlin (2015) agrees that the pro-expansion Republicans were prepared to do what they felt was right regardless of whether or not they would be given political support in their reelection campaigns. Representative Shope (2015) explains that he never received any sort of promise of financial support in exchange for his vote, but what did make him feel more comfortable in his decision was the governor’s reassurance that she would remain on his side in his reelection campaign. He states:

There was never any promise of funding or anything like that, but there was always a assurance that look, you’re doing the right thing…As far as I can remember anyway, nobody was talking about, ‘Oh yeah, as soon as this is all done we’re gonna go out and do this fundraiser or that fundraiser.’ None of that ever happened. But …I had numerous conversations with the governor, and she reminded me that she had, in her 30 year career, had never lost an election, and that she would then work just as hard to ensure that I didn’t lose. And obviously that makes you feel good, when you have somebody who’s committed to helping you in your corner.
According to Taylor (2015), not all of the 14 Republicans who eventually voted in favor of expansion were from moderate districts—some of them came from solidly Republican districts. From his perspective, the Chamber’s record in getting legislators who broke party lines reelected may have helped make some Republicans more comfortable in their decisions to vote for restoration/expansion. In a previous year, the Chamber encouraged a handful of Republican legislators to reject what the Chamber felt were extreme pieces of anti-immigration legislation. According to Taylor, with the Chamber’s support, all of those legislators were re-elected. Referring to the pro-expansion Republicans, he states, “We were able to point to our record…I would like to think the fact that the Chamber was right there gave them some comfort that we would stand behind our friends.” After the expansion bill passed, the Chamber made large contributions to the governor’s Arizona’s Legacy PAC and was also very active in using its own independent expenditure campaign to endorse, advertise for, and provide financial support to pro-expansion Republicans.

The governor and pro-expansion interest groups were ultimately successful in helping to get supportive Republicans re-elected—out of the 13 pro-expansion Republicans that ran for re-election (one of the original 14 left the legislature in August 2013), all but one of them held on to their seats. As Plese (2015) explains, this was no easy feat:

Very conservative Tea Party Republicans in the state fought really hard and tried to make sure that these Republicans were not re-elected. And precinct committee people actually came out against these people very early on, and the governor herself. And it was noisy and it was ugly…So there was no assurance we were gonna get these people re-elected, but everybody worked very, very hard to make sure that they were re-elected.

The consensus of most Restoring Arizona leaders is that the one legislator (out of the 14) who was not re-elected lost for reasons unrelated to his support of Medicaid expansion. As Plese (2015) explains, he was replaced by a strong Democrat candidate (who was actually a physician
who took care of Gabby Giffords after she was shot), and so this was not an instance of Tea Party leaders following through successfully on their threats to oust pro-expansion Republicans.

**Grassroots Initiatives**

*Education*

The Restoring Arizona grassroots campaign for expansion focused first and foremost on educating the public (in addition to legislators) about what restoration/expansion was and why it was an important step for the state of Arizona. Coughlin (2015) explains:

So once [Governor Brewer] committed to it, then we began…with the Arizona Chamber of Commerce, the Arizona Hospital and Healthcare Association, to engage in a vigorous effort to educate people in Arizona about restoration and what it meant to the state budget, why it was important, why it was fiscally the right decision to make for the state. And we held on to those talking points that we developed through the polling mechanisms, and did multiple press conferences with the governor, did multiple opinion pieces, did multiple email, you know, we had a website set up through the Arizona Chamber of Commerce which was essentially our message platform where we would do emails and updates and anecdotal stories about people and coverage and also about the fiscal impacts of the program…[We] really kept up a fairly vigorous drumbeat of messaging through multiple media programs, emails, direct mail, print, collateral, organizational support, hospital nurses, doctors.

Meaney (2015) adds that in addition to mobilizing employees and community members to participate in rallies and engage in other grassroots advocacy activities, her client, Abrazo Health Care (a network that serves the greater Phoenix area of six hospitals, two emergency centers, and a heart institute) also helped educate the public by organizing hospital tours for the public. She explains, “We did hospital tours to bring people to our facilities so that they could very directly see exactly what those hospitals faced on a daily basis, what their ERs were like, and you know, how they were really operating on very tight margins and how important the Medicaid spending was to their operation.”

Johnston (2015) describes additional ways in which the coalition departed from traditional grassroots advocacy strategies:
Something that we normally haven’t done in the past: we went out to precinct committee meetings, Republican precinct committee meetings, met with, you know, precinct men and women, Republican women’s groups, to try to explain to them why this was important. And this was to sort of help shore up the Republican coalition that was really going out on a limb to vote for this, because they were getting all sorts of hate mail…we had to give political cover.

*Mass Rallies*

The Restoring Arizona coalition put together multiple large, pro-expansion rallies, many of which were hosted on the lawn of the state capitol in Phoenix. Plese (2015) explains:

[The Chamber of Commerce] were the ones who worked closely with the governor’s office to organize five different rallies at the state capitol. So each rally had a different focus—there was one that was like all the provider groups, then there was one with patients, there was one with the cancer patients and the really critically ill people, there was one for disabilities, so they focused on the different patient populations as well as the providers that provide those services.

When asked about AzHHA’s role in the Restoring Arizona rallies, Johnston (2015) explains:

We contacted our members, they brought a nursing staff, administrators, medical staff down, I mean they, we just, it was really grassroots advocacy. Getting on the phone with your members saying, ‘Hey, there’s a rally at the capitol, the governor’s going to be there, you know we really need to support her, do you have staff that would be willing to come down?’ Also then through the coalition website we were able to get folks to sign up to receive email alerts. So you know, like every hospital association we have weekly newsletters that go out, and then we have sort of alerts for special things, so we contacted our members through those mechanisms whilst making some phone calls. We also did hosts to the governor as she did a tour around state…For example, she went up to Mohave County and our CEO went up there with her, and they met at the hospital and then the Chamber of Commerce to talk about the proposal and kind of explain to the people why this was important.

Taylor (2015) similarly describes interest groups’ success at mobilizing employees and other citizens to participate in the rallies and “show support for the governor.” While the governor hosted these press conferences and rallies on the capitol lawn (and her staff put a lot of work into organizing these events), the Restoring Arizona interest groups were responsible for eliciting mass attendance and public support. He states:
So as part of the coalition we had folks that had big email lists and mailing lists. You know, you have like…physicians or nurses associations—they could blast their membership and say, ‘Look, we need you, we need you on Tuesday at 2 o’clock out at the capitol, this is big, we just need you to stand with the governor.’ And, you know, it makes for quite a picture when you have doctors showing up in their white coats and you’ve got nurses out there in their scrubs, it’s like wow, these are real professionals who care about this…I think email was probably the biggest, and social media, because the Chamber, you know, big membership but getting a bunch of executives out standing on the lawn in suits, it’s not the same thing as your groups that have that sort of larger, specific profession following. And so they were able to move people, and they just did a great job…the Chamber played a sort of convening role and made a lot of leadership decisions about the direction of the campaign, but we can’t take credit for getting those bodies out there the way some of those other groups did.

When asked whether the rallies were generally well attended, Plese (2015) responds, “Very well attended. By both sides—by both opponents and proponents. And there was a lot of media coverage around those. So it was quite interesting. So you could get five to six hundred people out on the lawn at the capitol in these rallies. A lot of energy and a lot of yelling back and forth.”

Taylor (2015) also highlights two unique ways in which the coalition made use of the rallies to aid its lobbying efforts in ways that went beyond just providing a physical demonstration of support for restoration/expansion. First, Restoring Arizona set up tents with computers at the rallies, into which citizens could enter their names and addresses and automatically generate letters to their legislators urging them to support restoration. Second, Restoring Arizona had film crews at the rallies to film constituents talking about why the restoration/expansion issue was important to them (many of these clips were used in future media-relations initiatives and posted as “testimonial videos” on the Restoring Arizona website). Thinking back to the rallies, Taylor reflects, “It was extremely impressive and ultimately effective.”
Media Relations

The effectiveness of the pro-expansion messaging and grassroots campaign appears largely due to Restoring Arizona’s extensive and well-coordinated media relations strategy. As Meaney (2015) explains, the Medicaid expansion implementation battle generated a huge amount of media attention. She states:

In my time at the legislature, I’ve only been doing this—this is my 18\textsuperscript{th} legislative session so I haven’t been down there forever, but certainly in my time this was the most significant policy issue that I was aware of that faced the state…This probably was as big as 30 years ago when we got into the Medicaid program…This was a really significant news story. There was a lot of interest from local TV stations, and capitol reporters, and our state newspaper the Arizona Republic.

Plese (2015) explains that Restoring Arizona’s media relations strategy was executed with great coordination and efficiency in order to respond to all of the media requests while ensuring a high degree of message cohesion:

A lot of the media efforts were coordinated through [Restoring Arizona] as well. And so we ensured that if we got media requests, that it was going to the same channels, and that we had people who had the talking points and were very well versed in the topic so that they could quickly and efficiently make sure that they had answered those questions and were responding to the media requests. And they also coordinated the television appearances, the radio…Now those of us that were partner organizations did some of that ourselves, but we made sure that we were on the same page as far as the talking points, and made sure that we reported back to the larger organization how we had responded, who had made the media request, and all that type of thing.

According to Meaney (2015), “The lions share [of the media coverage] was earned media,” but paid media was also an important element of the Restoring Arizona campaign. One particularly powerful television advertisement (that is posted on the Restoring Arizona website) states, “When folks go to the ER and can’t pay, you get stuck with the bill…But conservative governors are protecting taxpayers and saving hospitals.” After displaying images of Brewer and other conservative governors, the ad ends with the message, “Tell your legislators to support the Governor’s fiscally conservative Medicaid plan” (restoringarizona.com). In addition to the
television ads, Restoring Arizona created numerous other pro-expansion videos that were disseminated through YouTube, the coalition’s website, or other social media platforms. Many of these were testimonial-style videos (often filmed on the lawn of the capitol during the rallies) featuring doctors, nurses, patients, and other ordinary Arizonans making passionate and personal cases for the importance of restoration/expansion (restoringarizona.com). An additional YouTube video titled, “Do the Math—Arizona Medicaid Made Simple” laid out the governor’s three options regarding this health coverage policy dilemma (do nothing, lose the rainy day fund, or extend coverage at no cost) and concisely but clearly demonstrated why the third option (enacting an expansion to extend coverage) made the most sense for the state (“Do the Math” 2014).

Representative Carter (2015) highlights the importance of the “media blitzes” to the overall grassroots strategy. She states:

As we got closer and closer and closer to the vote…we were trying to get more and more and more people involved in support. We had rallies down at the capitol, we had press conferences, we had media blitzes to make sure—that was really important…They communicated directly to Arizonans through Restoring Arizona. [The coalition] provided a YouTube video that explained, ‘What is this policy? What are we really doing?’ They did that, they did media buys, they took out ads, because we were really trying to communicate with the public what it was that we were doing. Because the sound bite against it was ‘Obamacare.’ And we had to explain why this wasn’t, why Arizona was in a unique position, pretty much unlike most other states.

Taylor (2015) also emphasizes the importance of the social media element of this campaign:

I talked about not over estimating the effect of social media campaigns, but also let’s not underestimate it. Because what a great way to get out to social media and say, ‘Alright guys look, this is a big week for us, it’s really come together and if you’re meeting with your local legislator then let them know what’s going on.’
Success of Grassroots Education/Advocacy Strategy

The Restoring Arizona education effort does appear to have helped build some degree of public support for restoration/expansion. Polling data showed an increase in public support for restoration over the course of 2013. Paul Bentz, Vice President of Accounts and Strategy at HighGround Public Affairs Consultants (Coughlin’s firm), conducted a statewide survey of 500 “high-efficacy voters” on behalf of Restoring Arizona in August 2013 (after restoration passed). Commenting on the survey’s results in a Restoring Arizona press release, Bentz stated, “This is a steady increase in support for Medicaid restoration from previous surveys. Voters understand what is at stake and believe that restoration is the best choice for Arizona” (“Survey Shows Voters Overwhelmingly Support Medicaid Restoration” 2013). Representative Carter (2015) also references the growth in public support for restoration demonstrated in polling data, and explains that she believes the education and advocacy work contributed to this increase. She states:

There was a lot of support from the general public based upon a lot of the advocacy work…If you poll the general public of Arizona, they are pretty much overwhelmingly supportive…But when you drill down into the different political groups, Democrats support it almost unanimously. Republicans…at the beginning, definitely less than 50 percent supported. And right after it passed, and we had done a lot of education, support was growing and it definitely did reach over 50 percent in what we would call ‘primary election voters.’ And that’s where we get elected as Republicans in Republican districts—is the Republican primary. Not in the general election. Because like in my race, I didn’t even have a Democrat running this last time.

Restoring Arizona seems to have made a concerted effort to ensure the grassroots campaign had strong reach into all regions of the state. Johnston (2015) describes the way in which the coalition utilized individuals’ connections in their home cities/regions:

I live in the city of Tempe, so part of what I did was I helped identify kind of thought leaders within the city of Tempe to the coalition, and then those folks kind of leading the coalition would reach out to them and they would write letters to the editor. So you had, maybe, mayors who normally wouldn’t have been involved in these issues, or city councilmen, or maybe it was just somebody even on the school board, but folks who
were well known within local communities—they would then write letters to the editors in their local papers. So it was a huge grassroots effort.

The extent to which this campaign successfully educated the public in regions throughout Arizona, however, remains unclear. Representative Shope (2015) describes how in his rural district, the average voter did not really understand the restoration/expansion issue. He states, “When I went door-to-door, and I knocked all summer long, in all the doors that I knocked on I…never had one person ask me about Medicaid…It was a truly complex issue that I don’t think people really were able to wrap their heads around, it took me a long time to wrap my head around!...It was just not on the radar screen of the average person out there.”

Representative Carter (2015) says that she, too, was rarely asked about Medicaid expansion directly while knocking on doors. However, she was often asked about the issue indirectly in response to the opposition’s efforts to frame her vote for expansion as a vote to raise taxes or a vote for Obamacare. She explains:

The first set of [hundreds of] signs that went up in my district said ‘Heather Carter raised your taxes.’ And what they were referring to was the hospital assessment that was going to pay for the state match sent to Washington to draw down the additional dollars. So people would ask me at their doors, ‘What’s with this Heather Carter raised taxes?’ And I put up a matching sign that said ‘Heather Carter cut your taxes.’…So that's what we ended up talking about a lot. It wasn’t related to what was this Medicaid thing, specifically…And then a week after that, hundreds of little red arrows came out and said ‘Voted for Obamacare.’ So when those arrows went out people would say, ‘How can you vote for Obamacare? I thought you were a state representative?’ And I’d say, ‘Exactly’ and then explain that to them. And so it was more political conversations than it was anything else. Now if I saw somebody who really kind of follows the work we do down at the capitol, if they were a supporter they would talk about that or if they were in opposition they’d talk about that.

Even if the Restoring Arizona grassroots campaign was not entirely successful at educating the general public in all regions of the state, the grassroots effort does appear to have been essential in countering and neutralizing the large-scale advocacy efforts of the opposition on this issue both before and after the legislature passed the expansion. Highlighting the
importance of Restoring Arizona’s allocation of resources to the grassroots effort, Representative Carter (2015) explains:

This was extremely, extremely partisan. Without the grassroots effort that the business community and the governor and everybody put together, it’s very difficult for us [legislators] to communicate with massive amounts of people, because it requires money to communicate. You either have to do mailing, you have to do advertising, you have to do radio, and we were doing, we were doing interviews, but there’s only so much—It’s a PR campaign, and a PR campaign costs money. So as individuals, you know, we raise money for our elections, but we don’t raise the kind of money that it takes to [do] a big PR campaign like that.

**Additional Influential Factors**

**State Health Policy History**

All of the Arizona experts who were interviewed for this project cited the importance of Arizona’s unique history regarding Medicaid coverage as an important factor in the success of the Restoring Arizona campaign. The two most important events in the state’s health policy history were Proposition 204, the state’s voter initiative requiring coverage of all individuals up through 100 percent FPL, and the subsequent 2011 enrollment freeze that took place when the state faced budget challenges and said that there were no available sources of funding for providing coverage to additional childless adults (see “Arizona Background” section for a more detailed explanation of these events). These factors were what allowed for the framing of Medicaid expansion as (largely) a *restoration* of coverage that the state had provided to Arizonans in the past, rather than an *expansion* of the program to cover a large group of people that had never before received Medicaid benefits.

Whitney (2015) explains the importance of this policy-history element, stating, “There really is a distinction in Arizona because of the way our Medicaid program looked prior to the ACA that isn’t true in a lot of cases. And I think in a large part, because of that fact we were able to have success when a lot of other places weren’t.”
Explaining that he does not think the expansion effort would have been successful without the state’s unique coverage history, Coughlin (2015) states, “I thought that a base-level of understanding of the Arizona discussion about this issue was that the state had voted twice, on a statewide ballot measure, to support health care for people up to 100 percent of the federal poverty level…I believe [our policy environment] was largely shaped by two successful statewide ballot measures.”

Given these statements, it is clear that the context that provided the foundation for the pro-expansion battle was very different (and likely advantageous) in Arizona compared to other states (including Virginia). Yet according to Meaney (2015), the state’s history would not have been enough to get restoration/expansion through the legislature without the advocacy efforts of interest groups. She states:

I don’t think that Medicaid would have passed without the large-scale advocacy effort from the business community, from the stakeholders, certainly without the governor’s support. You know, I’ve heard some people say (who were not really part of the process) looking back on it that oh, as soon as Governor Brewer came out in her state of the state to support it, this was a done deal, this was like a hot knife through butter, super easy-peasy. I think, certainly from my perspective having been in the trenches of the day-to-day on this, it was a pretty significant undertaking, and it was a pretty tough mountain to climb even with all of that support. So I don't think it would have been done on its own, I don't think our prior state’s history, our support of funding this population, even though the voters had approved it twice before and we used that in our messaging, I don't think that would have been enough to get it through the legislature on its own.

*Gubernatorial Influence*

Many leaders of the Restoring Arizona campaign emphasize the importance of the Governor’s relentless efforts and dedication to making the restoration initiative successful. Coughlin (2015) explains, “What she was trying to do was in the best interest of the state as a whole, going forward, without regard to her future political ambition—she was putting it all on the line to make sure that the state could get through what I would consider the worst of
economic times in the history of Arizona.” Meaney (2015) underscores the importance of the
governor’s leadership in the pro-expansion movement, stating, “When [Governor Brewer] came
out so strongly in her state of the state, you know, without her leadership I think it’s fairly—it’s
fair to say that it would not have passed without her strong support.”

Coughlin (2015) offers an example of a time at which the governor’s leadership expertise
proved essential to the expansion initiative’s success:

We thought we had a path forward, and then [the legislature was] gonna adjourn for the
weekend. And it was getting towards the end of the legislative session and the budget
needed to be adopted, and Governor Brewer (and one thing is she’s a tremendous—she
knows how to count votes and she’s got an extraordinarily good political sense about
her), and she made the decision on her own, once she saw what was happening in the
legislative cycle, that she was gonna call them into special session over the weekend and
run the bills. And she knew she had the votes, if her team stuck together, we would have
the votes to move the bills…And over about a three-day period she had accomplished
what she had set out to do.

Though he agrees the governor’s efforts were impressive, Taylor (2015) underscores the
importance of the support she received from interest groups. When asked whether he believes the
restoration would have passed if the historical context were the same and the governor fought
just as hard for expansion but did not have the coordinated interest group effort behind her,
Taylor explains:

The governor is only one person, and how does she convey to the lawmakers look,
there’s an entire business community who is standing up behind you, employers across
the state are standing up behind you. She wouldn’t have been able to make that case, at
least not with any credibility, or at least with not as much credibility. So I think the
campaign, again, not from some sort of predictable left-wing group, but from the business
community—I think that made a huge difference.

Representative Carter (2015) makes a similar point. While she describes Governor
Brewer’s leadership as vital to the success of the expansion effort, she does not believe that the
governor would have accomplished this without the interest group coalition behind her.

Representative Carter explains:
I firmly believe that without Governor Brewer leading this initiative…there is no way we would have gotten this passed. It required a very strong leader in the majority party—and in Arizona that’s the Republican party—it required a very, very, very strong leader to be sort of the number one cheerleader of this policy. And then as sort of a leader of this, she brought together the business community to show why, from a business perspective, this makes perfect sense. And it was with all of this work together—if any one of those pieces were not on board, I’m not sure we would have gotten this passed. If we didn’t have the business community behind this, if we didn’t have the governor behind this, I don’t know if just the legislature could have passed it. If the governor wasn’t behind it but the business community was, I don’t think we could have got it passed. If the governor did support it but the business community didn’t, I don’t think we could have got it passed. I mean, I really think it’s just, it took, you know, legislators who were fundamentally willing to do this for whatever their reason was, and it took the business community, and it took the health care community and the governor all working together (and I put the health care community in with the business community).

While the Governor’s steadfast commitment to restoration/expansion and tireless efforts to see restoration through were certainly courageous and admirable, many state governors who were similarly committed to expansion and active in campaigning for it have not been successful. Governor Terry McAuliffe in Virginia is one example of a governor that has failed to enact an expansion despite making this issue a top priority and campaigning for it vigorously across the state. In light of this comparison, it seems that the political party of the governor may be highly significant—it may be advantageous, in some ways, for the governor to come from the party that commonly opposes the policy.

When asked whether expansion would have had a chance of passing in Arizona if it was an equally committed Democratic governor rather than Brewer, a Republican, pushing for expansion, Meaney (2015) responds with uncertainty. She states, “That’s a hard question to answer. You know, the governor is a very powerful person, but the governor is one voice and you still need to get your votes through the chamber. And Democrats don’t have a lot of numbers in our legislature so I think without a change in the makeup of the legislature it would have been difficult under that scenario to move it through.”
According to Taylor (2015), passing restoration in Arizona potentially could have been more difficult had Brewer been a Democratic governor. He states, “At least in the case of the Republicans who supported the governor’s position, they were able to say, ‘I’m a Republican and I’m standing alongside my Republican governor.’ Had it been a Democrat governor, it probably would have been tougher, now that I think about it, because you would have a Republican saying, ‘I am crossing over to support a Democrat governor.’”

Representative Shope (2015) emphasizes an additional aspect of the Governor’s ideological/political party position that allowed her to achieve success in this implementation initiative—her strong reputation within the Arizona Republican community. Arguing that it would have been almost impossible for a Democratic governor to get Medicaid expansion passed in Arizona, Representative Shope (2015) states, “This was an issue that she could push because she had conservative street credit. I don’t even think that most Republican governors could have done this. She had such street credit in conservative circles that she was able to push this and not get labeled as a RINO, except for those people who were on the absolute fringe of the party.”

Whitney (2015), however, argues that a switch in the party of the governor may not have made much of a difference in the attainment of legislators’ support. She states, “To the extent that Republicans were supportive of the policy, a lot of them were there because they could not reconcile uncovering that many people and looking at what would happen to the overall health care system. So I think that that still would have been something they would have had to struggle with regardless of the party of the governor.”
National Government Support

When asked whether the national government could have done more to support the
Restoring Arizona initiative, interest group leaders and other experts generally advise that
remaining distant was the best approach for the Obama administration. Taylor (2015) explains:

Unless the [policy] is some sort of center-left or liberal initiative that you could use your
Organizing for America organizing arm for, I would say stay out of stuff like this.
Because…especially in states that are Republican states, all it does is confirm your
opponent’s worst suspicions. ‘Oh, see! This is an Obama administration plot to take over
fill-in-the-blank issue here in Arizona!’

Meaney (2015) offers a similar caution about federal government involvement:

Arizona’s a state where we try not to ever utter Obama’s name at the legislature. We’re
not exactly embracing of the federal government here, so I think certainly [the Centers
for Medicare & Medicaid Services] played a huge role in this, and there were a lot of
discussions with CMS as we worked on different elements to it, but you know, less is
more when it came to advocacy efforts or weighing in with lawmakers.

Even when prompted to consider a more behind-the-scenes form of federal involvement,
perhaps with federal officials not directly tied to Obama contacting and helping to coordinate
interest groups, Taylor (2015) is doubtful that federal involvement would do more good than
harm. He explains, “At a grassroots level, people think Jeb Bush is a liberal, you know?...Name
your national Republican, they are very suspicious of them. And so I think when you have this
sort of, ‘Hi, I’m from Washington, I’m here to help,’ it goes south.”

As discussed in the previous section on coalition building in Arizona, Coughlin (2015)
asserts that the federal government was most helpful in providing clarity about the expansion
program in the Sebelius letter that HHS released in December 2012. By specifying in a timely
manner that states must either opt-in and cover the entire population up to 138 percent FPL, or
receive no money for expansion, Coughlin believes the federal government provided a “certain
policy field” where choices were clear for state leaders. However, Smith (2015) takes the
opposite approach and argues that the federal government could have been more helpful by allowing the state greater flexibility in designing the specifics of the expansion plan. He explains:

They could have made it a lot easier on us by granting us certain concessions that we were interested in that they refused to do at the time but they have since done for other states. You know, whether it’s co-pays or other reform efforts that are being pursued now by other governors that they have approved, and they just were unwilling to do any of that with us at the time.

Future Outlook

Once the expansion battle moved to the courts (after The Goldwater Institute, representing 36 Republican lawmakers, sued the state over the hospital assessment funding mechanism), the fight became largely out of interest groups’ hands (see Arizona background section for a more detailed explanation of the lawsuit). When asked what work has gone into fighting to uphold the restoration since it passed in the legislature by the University of Arizona Health Network and/or other interest groups, Whitney (2015) responds:

Not a lot, because…it’s not our fight. We don’t have any standing in the conversation. I know that Restoring Arizona and the hospital association and some other folks have written letters in support…We’ve publicly been supportive of the assessment and that we think it was a fine thing to do, but outside of that there isn’t really anything we can do really. It’s between the governor’s office and the legislators that are suing her.

According to Johnston (2015), AzHHA’s only direct involvement thus far has been to file two amicus (“friend of the court”) briefs, at the trial court and appellate court levels, in support of the assessment. In these briefs, AzHHA argued that the hospitals are the ones who have to pay the assessment, and the legislation’s prohibition of hospitals passing the assessment on to patients means that no taxpayers will be impacted by it. But despite these arguments, courts ultimately ruled that the legislature had standing to sue (the Arizona Supreme Court announced its final decision on December 31, 2014). The case is set to proceed on July 10, 2015 in the
Maricopa County Superior Court (Associated Press 2015), and Johnston explains that attorneys have reached out and asked AzHHA to file another amicus brief for this stage of the lawsuit. At the time, AzHHA was still in the process of deciding whether to take that step. Johnston said that she believed filing an amicus brief would probably be the most the association would get involved—from her perspective, it did not seem to make sense for AzHHA to intervene beyond that. If the court ultimately decides that the assessment is a tax requiring two-thirds support from the legislature, Johnston says AzHHA would have to talk with its members and stakeholders about plan B options, including the possibility of attempting to refer the assessment to the ballot under the referendum authority in Arizona.

As of April 2015, current Arizona Governor Doug Ducey has not announced whether he will continue the state’s defense in the lawsuit. If he decides not to continue the defense, it is unclear whether the hospitals, the health care industry, or another party would seek to intervene to defend the lawsuit. Taylor (2015) is not aware of any engagement by the Arizona Chamber in directly lobbying Governor Ducey or his office regarding the court case. While the lawsuit unfolds over the coming months, Arizona’s Medicaid restoration/expansion program will remain in jeopardy.

**ANALYSIS & DISCUSSION**

**Interest Group Coalition Composition & Coordination**

*Composition*

Many important differences exist between the interest group coalitions that were built in Virginia and Arizona. Both the HAV coalition and Restoring Arizona brought together a large number of supporting organizations committed to lobbying their state to expand Medicaid (see appendix for complete listing of each coalition’s named supporters). Yet a closer look at
coalition composition reveals that Restoring Arizona’s team was much better suited to overcoming conservative opposition to Medicaid expansion implementation.

While the governor’s office played a major role in the coordination of Restoring Arizona’s legislative advocacy effort, the Arizona Chamber of Commerce was a primary leader and coordinator of interest groups’ advocacy efforts across the state. Among other major responsibilities, the Chamber was in charge of fundraising, managing the use of Restoring Arizona funds, generating support from countless interest groups and associations across the state, coordinating the education and advocacy efforts of these groups (including those initiatives taking place outside the capitol), communicating the Restoring Arizona strategy with local chambers of commerce and other small interest groups, directing a sophisticated social media campaign, and financing/executing television advertisements and other pro-expansion media relations initiatives. The Chamber was certainly invaluable in offering resources, campaign strategy expertise, and manpower to the coalition. However, potentially even more significant to the coalition’s role in overcoming partisan opposition in this implementation effort was the fact that the Chamber is perceived to be a conservative-leaning organization that represents a broad range of industries. Given that Medicaid expansion, as a component of the ACA, is widely perceived to be a liberal policy, the Chamber can be classified as a non-traditional policy ally in the Arizona expansion battle.

Multiple interviewees involved in Restoring Arizona emphasized that having the Chamber leading the restoration effort rather than a more moderate or left-leaning organization was incredibly beneficial in the Arizona context. They generally expressed the belief that the Chamber’s leadership gave Restoring Arizona greater credibility in the eyes of Arizona legislators and citizens—the Chamber’s support of restoration/expansion was initially surprising
to many observers, and so it may have prompted many to reconsider the initial inclination to write restoration/expansion off as liberal scheme to impose Obamacare on Arizona.

Although Restoring Arizona was largely led by the Chamber and the Arizona Hospital and Healthcare Association, the coalition had very broad-based support from a range of other interest groups. Supporters include doctors’ and nurses’ alliances, hospitals and community health centers, health plans/insurers, disease-specific groups, multiple Indian tribes from across the state, and a variety of other public interest-oriented groups. This wide base of interest group support beyond the business community appears to have been very beneficial, especially to the Restoring Arizona grassroots efforts. These groups were able to mobilize their members to participate in rallies and other campaign activities. Crediting groups like the doctors’ and nurses’ associations for the mass attendance at the rallies at the capitol lawn, Taylor (2015) explains that the Chamber alone organizing a number of executives to stand out on the lawn in suits would not have been nearly as powerful as the broader attendance by doctors, nurses, and other professionals/ordinary citizens.

The Virginia Chamber of Commerce was also involved in advocating for Medicaid expansion in their state, yet their role was very different than the Arizona Chamber’s. According to Bailey (2015) and Gray (2015), VHHA and VAHP had to work hard to cultivate the support of the Chamber on Medicaid expansion, which implies that the Chamber was likely hesitant, at least initially, about supporting expansion. Even once the Chamber did come out in favor of expansion, it does not appear to have been a primary driver of the pro-expansion movement. Hanken (2015) characterizes the Virginia Chamber as being “pushed along” by VHHA, and while they included Medicaid reform and expansion as an element of their long-term Blueprint
Virginia economic plan, they were more willing than other groups to allow Virginia to take its time implementing an expansion.

Looking at the HAV coalition in comparison to Restoring Arizona, it is apparent that HAV was composed of and led by traditional policy allies of Medicaid expansion. The HAV coalition’s top leader—Jill Hanken—is a health law attorney at the Virginia Poverty Law Center. VPLC can be classified as a traditional policy ally in this context—it is unsurprising that that organization would favor a policy expanding health care coverage for low-income individuals. Additionally, the HAV coalition’s steering committee was composed largely of traditional policy allies (group names listed in the Virginia results section). Therefore, the composition and leadership-background alone of the HAV coalition does not seem to have challenged Virginia’s legislators and citizens to rethink their preconceived judgments of the Medicaid expansion in the way that the composition and leadership-background of Restoring Arizona did.

According to Johnston (2015), she believes that most of the organizations in Arizona that were proponents of expansion had some sort of relationship with Restoring Arizona. However, pro-expansion interest groups in Virginia were not unified under a single official coalition and operated in a much more fragmented manner. HAV did gain support from a large number of organizations, yet the coalition was not nearly as comprehensive as Restoring Arizona. Multiple groups did their pro-expansion advocacy separately from HAV—perhaps the clearest example of this was the informal coalition between VHHA, the Virginia Chamber, and multiple local chambers of commerce. The Virginia Association of Health Plans is another example of an organization that lobbied for expansion independently from any formal coalition. VAHP had the potential to be a powerful non-traditional ally in the campaign for expansion, and while it did sometimes work together informally with some other pro-expansion organizations in its lobbying
efforts, since VAHP members took divergent stances on the issue the Association was not able to be “out front” on this issue (Lynch 2015).

Another clear indication of the fragmented nature of the coalitions in Virginia is the inconsistency with which interest group leaders mentioned the HAV coalition in interviews. Several interest group leaders failed to reference the HAV coalition at all, even when asked directly about Virginia interest groups’ coalition building efforts around this issue. When asked about whether the Virginia Chamber ever worked in coordination with HAV, Virginia Chamber of Commerce Manager of Government Affairs Samantha Quig (2015) had never even heard of the HAV coalition. In contrast, the Restoring Arizona coalition was almost always one of the first things that Arizona interest group leaders mentioned when asked at the beginning of interviews to discuss their organization’s involvement in their state’s expansion battle.

An additional detail of major importance is the role of Planned Parenthood—a hugely stigmatized organization—in each state’s coalition. Not only is Planned Parenthood an active supporter of the HAV coalition (and one that is named on the coalition website’s list of supporters), but according to Hanken (2015), Planned Parenthood was one of the limited number of interest groups invited to participate in the weekly coordination/strategy meetings at the governor’s office. In Arizona, however, Planned Parenthood was not (visibly, at least) involved in the restoration/expansion advocacy efforts. When asked about why Planned Parenthood was excluded from the campaign despite being an organization in favor of expansion, Arizona interviewees are adamant that Planned Parenthood involvement would have done nothing but harm Restoring Arizona’s efforts to frame restoration/expansion as a conservative-friendly policy. Given this comparison, it appears that Planned Parenthood’s prominence in the Virginia pro-expansion advocacy effort could have detracted from expansion proponents’ ability to attain
conservative support. While Delegate McClellan (2015) does not believe that Planned Parenthood’s involvement damaged the Virginia pro-expansion campaign in any way, it is still possible that this stigmatized organization’s prominence in the campaign made support for expansion seem all the more dangerous to Republican (and especially socially conservative) legislators.

Coordination

Some observers may question the actual importance of an official coalition. If interest groups lobby forcefully for expansion and work together as necessary throughout the process, does it really matter whether they conduct their advocacy through a formal coalition? This research on interest group efforts in Virginia and Arizona reveals that a formal coalition can make interest group advocacy more efficient and effective in several important ways.

Overall, pro-expansion interest groups in Virginia took the less formal approach to advocacy described above. Many powerful organizations came out in favor of expansion and used a variety of lobbying strategies to push the state to implement some form of expansion. However, they were not all unified under a single official coalition. While VHHA representatives were on the HAV coalition’s steering committee, according to Hanken (2015) they are not listed as a supporter on HAV’s website and they chose to do their advocacy separately from HAV. The Virginia Chamber of Commerce also supported expansion, but according to Hanken, the Chamber was “pushed along more by the Hospital Association than they were by the HAV coalition.” Other individual groups, such as VAHP, engaged in advocacy independently of either HAV or the VHHA-led assemblage.

Another powerful advocate for expansion in Virginia was (and is) Governor McAuliffe and his office. Hanken (2015) explains that during the 2014 session, the governor’s office hosted
weekly meetings with pro-expansion groups. Although many HAV coalition members were represented at these meetings, the governor’s office did not technically, formally coordinate advocacy strategy with the HAV coalition, and the meetings included representatives of organizations that were not HAV members. In addition, the Chamber of Commerce was not regularly in attendance at these meetings (Hanken 2015). So while these coordination meetings may certainly have been constructive for the organizations present, it is unclear whether the governor’s plans or advocacy strategies were communicated effectively to the many HAV supporters and other organizations not represented at the meetings. From Cameron’s (2015) perspective, a lack of large-scale and consistent coordination was a major weakness of the campaign for expansion in Virginia.

Conversely, almost all organizations in Arizona that were supportive of expansion had some connection to Restoring Arizona. Johnston (2015) explains that while there was a core group of organizations that met weekly at the governor’s office and got major assignments from the Restoring Arizona leadership, she thinks that in Arizona, “most of the folks who were proponents of Medicaid expansion had some sort of relationship with the coalition.” Within Restoring Arizona, organizations from different industries/fields had different responsibilities. For example, among other duties, the Arizona Chamber was in charge of managing the external affairs/grassroots advocacy strategy, the governor’s office was the primary leader of the legislative effort, and the Hospital Association was responsible for contacting members to cultivate mass participation by patients and health care professionals at rallies/other Restoring Arizona events, negotiating the hospital assessment funding mechanism, and attaining patient stories to put a new face on the uninsured population. This massive and multifaceted effort in Arizona was executed with a high degree of coordination. Although it was not possible for all
pro-expansion interest groups to attend the weekly meetings at the governor’s office, the strategies discussed in these meetings with the coalition’s core leaders could then be disseminated down through multiple clear communication channels (for instance, Restoring Arizona strategy was communicated to local chambers outside of the greater Phoenix area through the Arizona Chamber Executives organization (Taylor 2015), and other associations communicated with smaller branches through social media or email listservs). These lines of communication ensured that even the efforts of smaller, local-level organizations worked in line with the larger coalition’s strategy.

A unified and well-coordinated coalition is also vital to ensuring the effectiveness of an interest group campaign’s media relations and messaging efforts. Without a formal, organized coalition to ensure a high degree of coordination, interest groups risk having their messaging appear fragmented and incoherent to their audience. When interest groups lobby independently rather than through an official coalition, their audience may feel bombarded with a variety of arguments coming from multiple different groups, all with unique interests and perspectives on the issue. Formal coalitions, however, appear much more likely to present a clear, consistent, and unified message on behalf of all of the supporter groups.

This disparity in messaging effectiveness is apparent through a comparison of pro-expansion messaging in Virginia and Arizona. In Virginia, individual organizations and groups executed independent messaging strategies, each using their own set of talking points. The Virginia Hospital and Healthcare Association, the state and local chambers of commerce, and the HAV coalition all messaged from different angles. According to Bailey (2015), VHHA coordinated activities with the HAV coalition and shared intelligence on messages that would work, yet they made a “tactical decision” to advocate from a separate angle. He explains, “[The
HAV coalition were] the passionate advocates for just straightforward Medicaid expansion. We were trying to make a case for something that is Virginia-specific and Virginia-unique. Just a different way to get to the same outcome.” Yet while this goal “outcome” may have been broadly similar in that all the groups supported some form of expansion of coverage, the proposed outcomes were very different on a more specific level. VHHA and the chambers placed a greater emphasis than HAV on the necessity of reform to the state’s existing Medicaid program before implementing an expansion, and advocated for a “Virginia-unique” (e.g. a private-option coverage expansion) rather than a federally-designed expansion. As a result of these differences in perspective, each organization used a separate list of talking points. Even though there may have been some overlap in arguments and the organizations sometimes shared intelligence on effective messages, many of the talking point lists were designed uniquely for and used by an individual group/faction of the pro-expansion campaign. According to Quig (2015), while the Chamber’s talking points were distributed to other organizations including VHHA, they were used primarily just by the state and local chambers (even VHHA, the Chamber’s close partner, had its own separate talking points). According to Cameron (2015), director of VCV (a supporter/member of the HAV coalition), “There wasn’t good enough coordination of talking points…We had talking points, but it was kind of like let’s get everyone to come and use them as you will, kind of thing.”

All Restoring Arizona interest groups, on the other hand, relied on the same (or a very similar) set of talking points. According to Taylor (2015), the Chamber relied on the same talking points as hospital groups and other interest groups involved in Restoring Arizona. In addition, there was a very clear process to ensure coordination in message dissemination. According to Plese (2015), pro-expansion interest groups in Arizona ensured that if they got
media requests, they were going through the same Restoring Arizona channels. The coalition had people who were “very well versed in the Restoring Arizona talking points and could quickly and effectively” respond to the media requests. While she says that individual partner organizations sometimes responded to these requests on their own, they “made sure that [they] were on the same page as far as the talking points, and made sure that [they] reported back to the larger organization how [they] had responded, who had made the media request, and that type of thing.” Plese also adds that the Restoring Arizona coalition coordinated most of the restoration campaign-related appearances on television and radio programs. In light of this comparative analysis, it seems likely that the lower level of coordination in messaging between interest groups in Virginia as compared to in Arizona had a profound impact on the clarity and effectiveness of pro-expansion advocacy.

Messaging through a formal coalition may also allow interest groups to avoid the public perception that their stances in favor of policy implementation are merely based on self-interest. Multiple interest group leaders in Virginia reported having their advocacy efforts challenged and/or weakened by the assertion that they only supported expansion because it would financially benefit their specific organization, business, or industry. For example, Gray (2015) explains that for VAHP and individual Virginia health plans, “The uncomfortable point is that this is a business opportunity for us…We can only go so far in lobbying because what happens is people say, well you’re self-interested, you just want more business.” Intriguingly, however, none of the Arizona interest group leaders mentioned this type of challenge, and so even if this challenge did exist, it appears that it was not a major concern. It therefore seems possible that advocacy through a formal coalition may help de-emphasize the self-serving motives of individual organizations. When hospitals, insurers, businesses, or other groups lobby for policy
implementation independently, it is easy to critique their positions for being based upon self-interest. But when the advocacy comes from a coalition of all of these disparate groups united around a single policy position, it is more difficult for opponents to claim that the policy is only supported by certain self-interested organizations and easier for proponents to make the case that the policy is beneficial to the state as a whole.

Commitment to and Prioritization of Policy Implementation

Another important dimension of interest group coalition advocacy is interest group commitment to and prioritization of the policy implementation campaign. Many groups in Virginia did prioritize advocacy on this issue, but this high level of commitment was not as consistent across a majority of pro-expansion groups as it was in Arizona. Medicaid expansion was the number one priority for VHHA in 2014 (Bailey 2015), and it has been the HAV coalition’s central focus over the past few years. Certain large individual hospitals, including VCU and UVA, also appear to have prioritized expansion advocacy. Many other interest groups, however, were not nearly as committed. According to Quig (2015), the Chamber does not see the fact that Virginia did not adopt an expansion after the hard-fought battle in 2014 as a failure. The Chamber supports expansion as a component of a long-term economic development plan for Virginia. Therefore, it is not rushing expansion implementation and maintains that Virginia must reform its existing Medicaid program before expanding. In addition, Gray (2015) explains that many Virginia groups had to divide attention between multiple issues. He states, “You have to keep in mind there are other things in the world going on than Medicaid expansion, lots of things. And everyone’s working on those things. And so to the extent that anybody has other issues they’re working on, they can’t put all their eggs in one basket, and no one does.” Due to these other concerns, many of the more peripheral HAV coalition members were likely unable to
prioritize expansion over all other matters—while the leading HAV organizations were very active in fighting for expansion, some of the other supporters were likely much less involved.

Overall, interest groups in Arizona seem to have prioritized restoration/expansion advocacy much more consistently. After making the decision to support expansion, Governor Brewer met with about 15 representatives of a number of different organizations and demanded their total commitment. Scott Smith (2015), Governor Brewer’s chief of staff at the time, recounts how the governor made it clear that “if [they] were going down this path, it was incumbent upon all of those in the room to make [restoration/expansion] their highest priority and do whatever was necessary from an advocacy standpoint to support her and the effort.”

Looking back, it is obvious that the central interest groups represented at that meeting and many more groups throughout the state followed through on that promise. As described in the next section on funding, a wide array of interest groups made significant financial contributions to the Restoring Arizona effort. Arizona interest groups’ full commitment to this implementation effort is also apparent in their generation of mass attendance at pro-expansion rallies, execution of grassroots initiatives in all regions of the state, execution of a large media campaign (including influential interest group-funded television advertisements), and multiple other highly organized Restoring Arizona campaign initiatives. According to multiple experts involved in the Arizona expansion battle, Medicaid expansion would not have occurred in Arizona without interest groups’ collective commitment to expansion advocacy and execution of such a massive, collaborative campaign.

Coalition Funding

An additional significant difference between interest group coalition advocacy in Virginia and Arizona is the discrepancy in funding invested in and available to the coalitions in each state.
Arizona’s funding was “never lacking” (Plese 2015), while a dearth of funding was a restrictive factor for the HAV coalition. While VHHA invested almost all of its 2014 advocacy budget in pro-expansion lobbying efforts, the Virginia Chamber’s involvement was mostly through the hired lobbyists they already had on staff, and so according to Quig (2015) the Chamber did not invest any significant additional funds in pro-expansion advocacy.

According to Hanken (2015), the HAV coalition is run on a volunteer-basis and does not have any funding. The coalition did get some voluntary donations from some of the supporters when it was first built, but Hanken explains, “That’s been a little bank of money that we’ve used over the last five-six years to do the work that we do.” Cameron (2015) adds that resource limitations inhibited Virginia pro-expansion groups’ ability to mount a successful grassroots campaign, whereas anti-expansion groups like Americans For Prosperity invested enormous sums of money in grassroots advocacy.

This discrepancy in coalition funding is curious given Virginia’s position as the more affluent of the two states (one might expect organizations in the state with the more prosperous economy to generally have more funds available for advocacy). Why would interest groups in Virginia, then, be less likely than their Arizonan counterparts to invest in a pro-expansion campaign? This incongruity may speak to individual interest groups’ perceptions of the strength and prospects for success of the coalitions themselves. Restoring Arizona’s emergence as a powerful, broad-based and highly organized coalition may have made supporters confident that their donations would be spent wisely and result in a successful outcome, while HAV’s more narrow composition and comparatively less powerful appearance may have made supporters more cautious about investing.
Even if they were unable to raise as much money for the pro-expansion effort as Arizona groups did, had Virginia interest groups been more unified, they may have been able to utilize the limited available funding in a more efficient and effective manner. Most of the funds donated to Restoring Arizona were pooled in a fund controlled by the Chamber, and then the leadership of the coalition strategically allocated these funds to various elements of the expansion campaign. In answering a question about the importance of Restoring Arizona as a central coordinating body, Whitney (2015) explains, “I think the money that was spent during this process was spent in a more effective manner.” With so many different groups advocating from separate angles in Virginia, each using their funding sources independently for their individual efforts, it seems likely that some funding may have been used redundantly or wastefully. By instead pooling their funding together and working towards a shared goal, Virginia groups may have been able to mount a more forceful advocacy campaign.

Timing

In multiple key ways, Virginia groups were not as prompt as their Arizona counterparts in mobilizing to advocate for Medicaid expansion. Within the span of a year, interest groups in Arizona were able to help convince Governor Brewer to support expansion, formulate a highly organized, Medicaid expansion-focused coalition composed of a variety of groups from across the state, implement a massive and effective grassroots advocacy campaign, attain the support of over a dozen Republican legislators, and ultimately get an expansion plan passed through both houses of the legislature and signed by the governor. But although Virginia groups have now had much more time to get organized (it has been almost three years since the 2012 Supreme Court decision), Virginia groups’ pro-expansion campaign is still behind where Arizona groups’ was two years ago.
Governor McDonnell’s staunch opposition to expansion may have caused part of this setback. It is unclear whether Virginia interest groups were more or less active in lobbying McDonnell to support expansion than Arizona groups were in lobbying Brewer, but it seems that McDonnell’s future political ambitions made the task of convincing him to support expansion much more difficult than the task of convincing Brewer. However, once Governor McAuliffe took office a year later, Virginia groups were still not effectively mobilized in some key respects. As described in the Virginia results section, Virginia groups did not come together in a formal, comprehensive, and unified coalition to advocate for expansion.

While that first year provided them significant time to develop and execute an effective education campaign, Virginia interest groups had not effectively educated the public and some legislators on the fundamentals of Medicaid expansion and the implications of the expansion decision for the state—according to Cameron (2015), even now in 2015, legislators, members of the public, and even employees in the health care sector still often do not have a clear understanding of why Medicaid expansion would be beneficial to Virginia. Until the 2015 legislative session, according to Steigleder (2015), many Republican legislators failed to even recognize that having a large uninsured population is a problem for the state—they relied on the argument that uninsured Virginians can simply access care through free clinics and the emergency room. With a more prompt and successful education campaign (targeted at both legislators and the public), the Virginia expansion debate could have been more focused on developing a solution to the Virginia health system’s problems from the outset with less time wasted on countering these erroneous arguments. These campaign shortcomings may have been avoided if certain key stakeholders—specifically, VHHA and the chambers of commerce—had been more involved in education and grassroots activity initially. According to Bailey (2015),
VHHA will be focusing heavily on pro-expansion grassroots mobilization in the upcoming year after doing hardly any grassroots advocacy on this issue in previous years. Bailey says that VHHA aims to educate the public and health care professionals on this issue and ensure that “legislators hear from the health care community pretty regularly about the need to find a solution to this issue.” While a successful grassroots initiative may be valuable now, it is unfortunate that this campaign did not take place earlier while the expansion issue was a priority for the legislature and for more interest groups around the state.

Virginia groups also appear to have been less prompt than Arizona groups in gathering and disseminating patient stories—key tools for redefining the image of the coverage-gap population and demonstrating the importance of expansion to the public. While Johnston (2015) admits that gathering patient stories was no easy task and that the coalition could always have benefitted from more stories, Restoring Arizona groups were able to gather a core collection of powerful stories for use in early 2013. Many of these stories were filmed and used in television advertisements or posted as testimonial video clips on social media platforms or the Restoring Arizona website (restoringarizona.com). While Virginia groups have also worked hard to gather stories, it was not until this past year (leading up to the 2015 session) that they began to have a lot of success in this effort (partially because they relied on navigators to gather stories, and navigators were limited in their ability to solicit stories until after the first year of enrollment). These stories are now being compiled into a “story card” that highlights patients from all regions of the state (Steigleder 2015), yet this type of advocacy tool would have been more valuable had it been available and utilized sooner (especially before/during the 2014 session when pro-expansion momentum was at a peak in Virginia).
Evidence also suggests that Virginia may have been slower to explore and propose certain policy options that could have helped build conservative support for expansion. Governor Brewer’s expansion proposal included the hospital assessment funding mechanism to pay the state’s share of expansion costs. Subsequently, AzHHA and other interest groups fought hard to solidify and maintain hospital support for this measure (Johnston 2015), which the governor and Restoring Arizona leaders saw as key to their efforts to attain conservative support for expansion. In Virginia, however, according to Bailey (2015) a hospital assessment was not proposed or discussed until recently, but it is “definitely on the table this year.” While Virginia expansion proponents may have been right to refrain from suggesting a hospital assessment initially in 2014 (when the adoption of other expansion plans seemed probable), it may have been beneficial for them to explore and propose this option once it became clear later in the 2014 session that the House was not going to budge in their opposition to the various other expansion plans.

Despite the comparatively short time-span of the expansion battle in Arizona, some Arizona interviewees suggest that the pro-expansion effort would have been more successful had it been accelerated even further. Smith (2015) and Representative Shope (2015) believe that the time for debate and on this issue between Brewer’s January 2013 announcement of support and the passage of expansion in June only caused the issue to become more polarized and lawmakers/other political actors (e.g. precinct committeemen) to become more entrenched in their positions. Smith says that if given the chance to go back to the beginning of the 2013 session, he would have recommended that Brewer immediately call for a special session in her state of the state speech to get the expansion bill through the legislative process more quickly. While this opinion is not shared by all Arizona interviewees—many emphasized the importance
of the advocacy campaign (that took place in the months after Brewer’s speech) for building expansion support—this viewpoint further emphasizes the importance of timing and suggests potential consequences of a prolonged implementation battle.

The consequences of delaying and drawing out the implementation process are more apparent than ever now in Virginia. Much of the expansion campaign’s momentum has been lost, and many key interest groups have significantly scaled back their involvement in the fight for expansion. Before the 2015 session started, according to Gunther (2015), the Republican-led legislature announced “in no uncertain terms that…there would not be a discussion of Medicaid expansion during the session.” In recognition of the political reality of the situation (and out of concern about wasting political capital or damaging long-standing, important relationships), Gunther explains that the hospital industry collectively decided to continue to educate about the impact of a failure to expand but not make a huge lobbying effort in 2015 to push through any sort of Medicaid expansion plan. Gunther also explains that a division is emerging within the hospital community as a result of the failure to enact an expansion. She says that some hospitals have begun to “cannibalize” one another due to the financial realities of the situation, and “certain hospitals [are] marching forward with their own agendas even if there isn’t a broader consensus among the hospital industry.”

Overall, these results suggest that timing is key to overcoming opposition to implementation. Sustaining a powerful and cohesive interest group campaign over a long period of time is extremely difficult, and it is therefore essential, especially in contexts where the opposition is organized and powerful, that interest groups favoring implementation organize and execute a campaign for federal policy in a swift and efficient manner.
Advocacy Strategy

Importance of Grassroots Initiatives and Education

This project’s results highlight a drastic difference between Virginia and Arizona in interest groups’ commitment to and success in executing grassroots advocacy strategies. Grassroots advocacy seems to have been a weak point of the overall lobbying effort in Virginia, whereas it was a chief component of the campaign for expansion in Arizona.

When asked about the Virginia Chamber of Commerce’s efforts to mobilize the public around their position on expansion, Quig (2015) says that the public was not a major target of their lobbying efforts—the Chamber mostly just focused on lobbying legislators directly. Bailey (2015) explains that VHHA has not done much grassroots mobilizing, and feels that consequently, employees in the hospital, health care, and health system community are not effectively making their voices heard on the Medicaid expansion issue. According to Cameron (2015), there is a dearth in education, outreach, and grassroots lobbying in the overall campaign for expansion in Virginia. She calls the advocacy on the part of interest groups that do focus on grassroots organizing “sporadic” and “hit or miss.” From her perspective, the groups that did make an effort to mobilize the public outside of Richmond were not able to fully reach and make an impact on all populations or regions, and the rallies that were organized to build and display support for expansion were not well enough attended. Largely as a result of the lack of an effective grassroots campaign, Cameron says that public education on the meaning and implications of Medicaid expansion was not at nearly the level it needed to be in order to push the state to expand—even health care professionals in Virginia are often “clueless” about key elements of Medicaid expansion and the larger Affordable Care Act. According to Delegate McClellan (2015) the ordinary Virginians who stand to benefit most from expansion—many of
whom live in heavily Republican districts—were not effectively mobilized to advocate for expansion. She explains, “If they spoke up and started putting pressure on their representatives then you might see different results, but they’re not organized…if you have a grassroots swell of people in those districts who directly would benefit from [expansion], you know, it’s hard to ignore your voters.”

In contrast, grassroots advocacy was a cornerstone element of the Restoring Arizona campaign strategy. Restoring Arizona hosted multiple large, well-attended rallies and aided citizens (especially those in attendance at the rallies) in contacting their legislators to pressure them to support restoration. These demonstrations of mass public support for expansion may have made tentative Republican legislators more confident in their decision to favor expansion. When criticized by the opposition for their support of restoration, thanks to the Restoring Arizona grassroots campaign they were likely able to point to clear evidence demonstrating the public’s strong support for their decisions.

The coalition also attempted to educate the public on this issue. Interest group leaders helped identify and generate support from local-level thought leaders (such as mayors, city councilmen, or school board leaders), and also went to Republican precinct committee meetings to explain the importance of restoration/expansion (Johnston 2015). The extent to which the coalition was successful at educating the public across the state is unclear. According to Representatives Shope (2015) and Carter (2015), non-activist citizens in their districts did not have a strong understanding of the issue or its importance to Arizona. However there is some evidence to suggest that the education/advocacy campaign achieved some degree of success—polling data showed that high-efficacy voters were more supportive of restoration in August 2013 than they had been previously (“Survey Shows Voters Overwhelmingly Support Medicaid
Restoration” (2013), and Representative Carter attributes much of the growth in public support to expansion proponents’ education and advocacy work.

Even if the education initiative was not successful in all regions of the state, the Restoring Arizona grassroots campaign appears to have been important to counteracting the large-scale advocacy efforts of the opposition on this issue (both before and after the legislature passed the expansion). The opposition had the advantage of a more succinct and striking message—“Obamacare.” Through the various grassroots strategies (e.g. holding press conferences, organizing rallies, disseminating pro-expansion testimonial videos, funding television advertisements, etc.), Restoring Arizona appears to have been successful at preventing the “this is Obamacare” message from dominating the conversation. Representative Carter (2015) also emphasizes the importance of the continuation of the PR campaign by the governor and pro-expansion interest groups even after restoration passed in the legislature. Without access to the resources necessary to communicate with massive numbers of people, legislators would have struggled to respond to the opposition’s efforts to punish the Republican legislators who voted for restoration in their reelection campaigns. She explains, “That’s where it becomes a team effort. And… it’s not like, ‘Vote for Heather Carter,’ it’s a team effort of, ‘Here’s what this is and this is why it’s important to Arizona.’”

*Lobbying Legislators Directly*

Interest groups in both Virginia and Arizona worked extremely hard to educate and lobby legislators on the importance of Medicaid expansion for their individual states. In both contexts, the focus of direct lobbying was to encourage legislators to forget about the national politics surrounding the Affordable Care Act and focus on the benefits that the expansion component of the federal policy could offer their own individual state. Expansion in Arizona ultimately passed
with the support of 14 Republican legislators. Expansion proposals in Virginia gained support from a few Republican senators during a significant portion of the 2014 General Assembly session (three Republican senators led the effort to establish a private-option expansion of coverage), yet these Republicans ended up voting for a budget that excluded expansion when the budget stalemate in the extended 2014 session threatened to cause a $1.55 billion revenue shortfall (Martz and Nolan 2014a).

One subtle yet important distinction between the lobbying strategies in the two states is related to the differing perspectives on the goal of lobbying efforts. In Virginia, the strategy was very much focused on pressuring legislators to support Medicaid expansion by informing them about the benefits of expansion for Virginia and the consequences (both economic and social) of not expanding. This was done through testimony before committees in both the Virginia House and Senate and meetings with individual or small groups of legislators (pro-expansion groups often targeted resistant Republicans, especially those from rural areas where the survival of local hospitals is often at stake, and the Republican leadership of both houses).

This overall approach to direct lobbying is a common tactic that was used by Restoring Arizona lobbyists as well. Interestingly, however, many Restoring Arizona leaders seem to frame the goals of their efforts somewhat differently. Instead of solely attempting to pressure or force legislators into switching sides, many interviewees describe lobbying and messaging tactics as intended to provide “political cover” for Republicans that were willing to support restoration. In their direct lobbying strategies, expansion proponents attempted to do this by working to maintain support from legislators who came out in favor of expansion while “isolating” the most radical opposition (Coughlin 2015). By isolating the most radical opposition, expansion proponents were able to make support of restoration appear as a more moderate stance and help
limit the opposition’s ability to gain ground. This subtle difference in lobbying approach (or objective) seems significant—political cover-oriented lobbying may have been more effective than typical strategies alone at earning the trust of moderate Republicans rather than alienating them.

Another important difference between the direct lobbying strategies used in the two contexts is related to the effort directed towards making expansion a nonpartisan issue. In Virginia, Democrats were the true drivers of the expansion campaign. The lobbying effort came largely from Governor McAuliffe (a Democrat), public interest-oriented groups that are often perceived as liberal (as previously discussed, the business community was also involved but not to the extent that they were in Arizona), and Democratic legislators like McClellan who were highly engaged in advocating for expansion (by speaking out in favor of it in the legislature, publishing op-eds, attending rallies, etc.). Lynch (2015) states, “Democrats were the ones that were charging this issue and were for this issue…The Democrats were the party of charge when it came to Medicaid expansion and it was a Democratic initiative, and so most of the work had to be done with the Republican leadership.”

In Arizona, however, there was a huge focus on ensuring that expansion did not become perceived as a Democrat-led, Democrat-driven issue. According to Meaney (2015), “You don’t want to brand it as a Democrat issue, you don’t want to brand it one way or another.” Arizona was partially able to do this because the state had a supportive Republican governor (Governor McAuliffe, on the other hand, only added to the perception of expansion as a Democrat issue in Virginia). Yet in addition to the efforts of the governor and the broad-based, business community-led coalition, legislators from both parties exerted a highly coordinated and disciplined advocacy campaign. Even though Democrats made up the majority of the supportive
community within the legislature, some of the 14 Republicans who voted for expansion (such as Representative Heather Carter, Chairwoman of the House Health Committee) actively lobbied for restoration/expansion and worked within the Republican caucus to build support for the plan. Referring to the efforts of these Republican lawmakers, Coughlin (2015) states, “It took an extraordinary amount of courage for them to work in those caucuses…It was brutal hand-to-hand intellectual combat with other members who were…the majority of Republicans were adamantly opposed to the Affordable Care Act and any portion thereof.”

While Democratic legislators in Arizona also worked hard to advocate for restoration/expansion, they exercised a great deal of discipline and control in their lobbying efforts to ensure that their messaging was consistent with that of Republican legislators, Governor Brewer, and Restoring Arizona. Coughlin (2015) explains that Democrats were, “as disciplined as policymakers as the Republicans who were supportive of it were.” He emphasizes that the Democrats spoke to the same points as other expansion advocates (for example, they talked about the fiscal consequences to the state of not expanding and the fiscal conservatism of a program like AHCCCS).

The advocacy efforts of legislators from both parties, as well as the messaging coordination between them, appears to have been greatly beneficial in helping expansion proponents overcome some of the divisive partisanship that has plagued many states on this issue. The battle over expansion in the Arizona legislature did not just appear to be a coalition of Democrats pushing this issue with support from a few hesitant, outlier Republicans. Instead, the expansion campaign in the legislature came from a bipartisan group of lawmakers working together and making the same arguments about the benefits of expansion for Arizona. It is unclear whether in Virginia, the advocacy of pro-expansion Democrats and the three Republican
senators who supported expansion was as well coordinated, so it is possible that they tried to implement this strategy but were unable to attain support from enough Republican legislators to present the pro-expansion push as a truly bipartisan effort. Arizona’s focus on preventing expansion from appearing to be solely a Democratic initiative, however, was fundamental to the state’s ultimate implementation success. As Meaney (2015) explains, “What I thought was really wonderful about the adoption of the bill was that for a brief moment in time, it was a really collaborative effort. It was Republicans and Democrats working together in the trenches to get this done.”

The partisan breakdown of each state’s legislature may have given Arizona an advantage over Virginia in passing expansion. After the November 2012 elections, Republicans held 17/30 seats in the Arizona Senate and 34/60 seats in the Arizona House. Yet although Democrats had a slim majority in the Senate during most of the 2014 expansion battle (and extended legislative session) until one Democrat’s resignation gave Republicans control in June 2014, Republicans had a solid 68-32 majority in the Virginia House of Delegates. Virginia interviewees consistently cited this huge Republican margin in the House as a major impediment to Medicaid expansion. They also add that three other related factors made the task of getting support from in the House even more difficult: gerrymandering, the growing confidence and power of the Tea Party in Virginia, and the remarkably high authority granted to the speaker of the Virginia House of Delegates. They explain that the districts in Virginia are drawn to favor Republicans, and so the only real threats that Republican legislators face are challenges in the primary elections (Democrats often have little or no chance of defeating Republicans in the general elections). Especially in the wake of the primary defeat of House Majority Leader Eric Cantor, the threat of Tea Party candidates taking out mainstream Republicans is very real to many Virginian
legislators, who have consequently become fearful of doing anything that might provoke such a challenge. Delegates also fear that support for expansion will result in punishment from the House leadership, which may impair their overall influence (on all issues, not just those related to health care). As McClellan (2015) explains, the speaker is “extraordinarily powerful,” and since he makes all of the committee assignments and decides who speaks on the House floor, “if he wants to shut you out he can.”

Some evidence suggests, however, that overcoming these significant obstacles was not a complete impossibility—there was some potential for gaining greater support among Republican Delegates in the Virginia House. Gray (2015) explains that he believes a large number of Republican legislators recognized that expansion was the right thing and wanted to vote for it, yet the leadership would not let them. Delegate McClellan (2015) agrees with this notion that a lot (or even a majority) of legislators in both houses philosophically believed that expansion was the right choice for Virginia—she argues that they did not vote for it because either the leadership would not let them or they were afraid of being defeated in the upcoming primary elections. Within this difficult context, however, she does see a chance for convincing Republican legislators (even in solidly conservative districts) to support expansion if their constituents are better mobilized to pressure them on this issue. She states, “I think if you have a grassroots swell of people in those districts who directly would benefit from [expansion], you know, it’s hard to ignore your voters.”

Arizona interviewees did not mention gerrymandering as a factor influencing the difficulty of attaining support from Republican legislators. While the speaker of the House in Arizona may not have the same extreme level of power that the Virginia speaker does, it is still significant that expansion passed in Arizona despite the firm opposition of the Republican
leadership in both houses. This case demonstrates that it can be possible to convince a significant number of legislators to break the party line and go against their leadership to support expansion.

Revisiting the Literature: Significance of Additional “Schools of Thought”

State Flexibility

The literature review conducted for this project highlights a divide between scholars on the efficacy of policy designs that incorporate significant state flexibility. Some scholars see a significant degree of state flexibility as essential to facilitating smooth policy implementation in highly partisan, polarized contexts (e.g. Dinan 2014; Doonan 2013), whereas another group of scholars caution that a high degree of state flexibility can be problematic during implementation for a number of reasons (e.g. Grogan and Rigby 2008; Manna 2010).

With regard to the implementation of Medicaid expansion under the ACA, the federal government has allowed a significant yet limited amount of state flexibility. It has granted states great leeway in designing the details of expansion plans—for example, HHS permitted Arizona to fund expansion through a hospital assessment, and it has approved multiple unique state expansion plans through 1115 waivers. HHS, however, placed a clear limit on the degree of state flexibility it would authorize by announcing that it would not permit states to receive federal funds for partial expansions covering less than the entire population below 138 percent FPL.

Some interviewees did cite state flexibility as a factor impacting their state’s expansion battle. In Arizona, Coughlin (2015) emphasizes the importance of HHS’ clarity in delineating that it would not support partial expansion plans—he says this announcement in December 2012 was helpful in that it “created a certain policy field where choices were clear,” and he is doubtful that Arizona would have otherwise enacted a full expansion. Smith (2015), on the other hand,
says that the federal government should have allowed Arizona more flexibility in order to support a smooth implementation process—he states, “they could have made it a lot easier on us by granting us certain concessions that we were interested in that they refused to do at the time.” In Virginia, state flexibility was beneficial to implementation efforts in that it allowed the state to design expansion plan proposals that took a more conservative approach to extending coverage to the low-income population (e.g. commercial alternatives to direct Medicaid expansion like Senator Watkins’ proposed expansion through the “Marketplace Virginia” plan). Without the potential to gain approval for these unique, Virginia-specific types of plans, Medicaid expansion would have been even more unlikely in Virginia.

While state flexibility does appear to have had an influence on the likelihood of Medicaid expansion policy implementation in both contexts, many of these factors were largely constant across the two states. The full 138 percent FPL mandate in order to receive federal expansion funds applied to all states, and HHS granted states similar amounts of leeway in designing unique plans for how, specifically, to extend coverage to the population below 138 percent FPL. Since Virginia has still failed to expand Medicaid even with a similar level of flexibility to Arizona, the full significance of the state flexibility variable in allowing states to overcome partisan opposition in the federal policy implementation process remains unclear.

Role of Governors

Literature on the role of individual political actors suggests the leadership skills and efforts of individual political actors play the largest role in determining the success of state-level policy implementation (e.g. Haeder and Weimer 2013). Overall, evidence from this project supports the notion that governors can be key actors in driving policy implementation. Both Terry McAuliffe and Jan Brewer made Medicaid expansion their top priority (especially during
2014 in Virginia and 2013 in Arizona), and worked tirelessly in regions across their states to explain and sell their positions. However, gubernatorial leadership alone (in terms of governors’ commitment to policy implementation and activism in lobbying for it) does not seem to explain the difference in implementation success between Virginia and Arizona. If this aspect of leadership were the key factor in determining states’ abilities to overcome partisan opposition to implementation, one would expect McAuliffe and Brewer to achieve similar levels of success in their implementation initiatives, yet this was not the case.

One aspect of governors’ roles that may be key, however, is the governor’s political party. The governor’s party appears to be an influential factor in two primary ways. First, a governor from a party that is viewed as traditionally opposed to the federal policy may give the governor greater potential to successfully overcome partisan opposition to implementation through his/her advocacy efforts. In the case of state fights to expand Medicaid, pro-expansion Republican governors may be seen as non-traditional policy allies because the Affordable Care Act is so widely viewed as a liberal policy. Republicans like Jan Brewer who come out in support of expansion, therefore, may have an advantage over supportive Democratic governors because of the surprising nature of their positions. Republican governors’ support challenges skeptical legislators, citizens, and other actors/observers to reconsider their own positions because they often realize that the governor must have a good reason for taking such an unexpected, politically risky stance.

A second dimension of the importance of a governor’s political party appears to be related to whether the governor’s party matches the party that controls the state legislature. As a Republican in a state with a Republican-controlled legislature, Jan Brewer was an extremely influential ally to the pro-expansion movement. As Representative Shope (2015) explains,
Governor Brewer had strong “conservative street credit”—her history of adherence to conservative values had earned her the trust of many conservative politicians, and it was difficult for opponents to call her a RINO (Republican in Name Only) or fault her conservative credentials in other ways. Coughlin (2015) also emphasizes the importance of her strong relationships with many of the legislators in the fight to win support for expansion. Referring to the Republican legislators who ultimately voted for expansion, he states, “They wanted to support the governor because the governor had been supportive of their policies...There was a deep friendship and respect amongst those legislators for her, and her for them.” These relationships (as well as Brewer’s reputation as a successful and powerful politician) also appear to have boosted legislators’ confidence that a vote for expansion would not necessarily bring about the end of their political careers. Representative Shope (2015) explains that Governor Brewer’s track record of electoral success and pledge to “work just as hard to ensure that [he] didn’t lose” made him “feel good” with the knowledge that he had “somebody who’s committed to helping [him] out in [his] corner.”

Comparatively, Terry McAuliffe appears to have been in a more difficult position given that he was a newly elected Democratic leader attempting to convince a Republican legislature to support expansion. McAuliffe did not have longstanding relationships with many legislators (especially not with Republican legislators) in the way that Brewer did. Many Republicans, therefore, may have been deeply concerned about taking such a large political risk to support an initiative led by McAuliffe, who was perceived by many conservatives to be untrustworthy.

As Taylor (2015) points out, at least Republicans in Arizona could justify their “traitorous” decision by saying they were standing alongside their Republican governor. The appearance of crossing over to support a Democratic governor, on the other hand, is much more
politically problematic for Republican legislators. However, McAuliffe would not be the first governor to push an expansion through a Republican-dominated state legislature. Arkansas Democratic Governor Mike Beebe signed a “private option” Medicaid expansion plan into law in April 2013 after winning bipartisan support for the plan in both Republican-controlled chambers of the state legislature. Rather than directly expanding the Medicaid program, Arkansas sought (and received) a waiver from HHS to use federal expansion dollars enroll the previously uninsured population below 138 percent in private insurance plans—an approach that proponents touted as a “conservative approach to reforming Medicaid” (Associated Press 2013). The Arkansas case demonstrates that enacting an expansion in a state with a Democratic governor and a Republican legislature is not an unheard of or impossible feat.

Many believe that the support of former Governor Bob McDonnell, a popular Republican (before the gifts scandal), would have made Medicaid expansion much more likely in Virginia. According to Bailey (2015), VHHA worked hard to try to persuade McDonnell that expansion was in Virginia’s best interest, but in the end he was “unwilling to take any steps that could be associated with implementation of what he calls ‘Obamacare.’” The intensity and effectiveness of these advocacy efforts (by VHHA as well as other groups) in comparison to Arizona groups’ efforts to persuade Governor Brewer to support expansion are unclear. Ultimately, however, Governor McDonnell’s future aspirations (at the time, he was widely perceived to have vice-presidential and/or presidential ambitions) may have precluded him from seriously considering coming out in support of expansion.

Although the governor’s political party variable appears to be significant, it is still unclear whether the support of a governor from the party that is typically opposed to the federal policy is more influential overall in overcoming opposition to implementation than the
independent variables of focus in this study: interest group coalition composition and advocacy strategy. As Taylor (2015) points out, the governor is just one person, and while she may be very influential, without interest groups behind her she would likely struggle to demonstrate the widespread benefits of implementing a given policy. However, future research is needed to isolate this governor’s party variable (controlling for other variables like interest group advocacy strategy) and test its significance.

State-Specific Characteristics

Multiple state-specific characteristics appear to offer potential insight into the difference in implementation success between Virginia and Arizona. One such characteristic that scholars posit mediates policy implementation success is state affluence. The literature offers conflicting suggestions on the direction of state affluence’s impact. Scholars like Kim and Jennings (2012) argue that fiscal incentives often prod less affluent states more than their wealthier counterparts to participate in federal programs, whereas Jacobs and Callaghan (2013) found in a study of state Medicaid expansion decisions that states with higher per capita income were more likely to implement expansions. On 2010 U.S. Census Bureau measures of per capita income by state, Virginia was ranked 7th while Arizona was ranked 40th (“Personal Income Per Capita in Current and Constant Dollars by State”). Therefore, this comparative case study contradicts Jacobs and Callaghan’s findings and is more in line with Kim and Jennings’ theory, since the less affluent of the two states (Arizona) is the one implementing an expansion. If Kim and Jennings’ hypothesis is correct, then perhaps Virginia did not expand because it could afford not to, whereas Arizona’s economic status made expansion more of a necessity. While this is possible, it is problematic to conclude that state affluence is the most important determinant of the success of federal policy implementation at the state level. As Jacobs and Callaghan demonstrate, many of the states that
have thus far refused to implement expansions are ranked even lower than Arizona on per capita income (i.e. Idaho, Utah, Alabama, Mississippi, and South Carolina ("Personal Income Per Capita in Current and Constant Dollars by State")). This suggests that other factors may be more influential than affluence in states’ abilities to overcome organized opposition to implementation.

A second state specific characteristic that scholars propose influences implementation success is the trajectory of established policy in the state. Jacobs and Callaghan (2013) suggest that state decisions on Medicaid expansion are influenced by prior policies concerning low income people and the uninsured—states that have a history of generosity in health care policy (expanding access to a wider population) are more likely to expand Medicaid. As described below, this variable appears potentially significant in this study.

Several Virginia interviewees cited the state’s history of being slow to implement federal policies as a factor that partially explains the fact that Virginia has yet to implement an expansion. Hanken (2015) explains the delay in implementing an expansion as a continuation of the state’s trend of “[taking] a long time to take up important opportunities”—Virginia was slow in adopting Medicaid when the program was first introduced, it was slow in adopting a legitimate children’s health insurance program, and now it is taking its time in implementing a Medicaid expansion. Yet in comparison to Arizona, this factor does not appear significant. While Virginia was the 42nd state (including the District of Columbia) to create a Medicaid program (“A Historical Review of How States Have Responded…” 2012), Arizona was the very last state to adopt one—it finally implemented AHCCCS in 1982 after holding out as the only state without a Medicaid program for a period of ten years (from 1972 to 1982) (Brecher 1984).

One historical advantage that Arizona did have over Virginia, however, was a history of providing health coverage to some “able-bodied” childless adults. Under Proposition 204, the
population of childless adults below 100 percent FPL was eligible for AHCCCS coverage. The fact that many individuals in this population lost coverage after the 2011 enrollment freeze, while unfortunate and problematic at the time, may have ultimately been beneficial to the state’s chances of expanding coverage to the full 138 percent FPL population. Arizona expansion proponents were able to use this history to their advantage by framing expansion as a *restoration of coverage* to the childless adult population that Arizonans had twice voted to cover. Additionally, Proposition 204 actually mandated that the state use all available funding sources to cover the population below 100 percent FPL. Expansion proponents were thus able to make the case that Arizona law required legislators to take advantage of the available federal expansion funds to re-cover the Prop. 204 population. Virginia, on the other hand, did not have any history of providing coverage to “able-bodied” childless adults, and the existing Virginia Medicaid program is actually very stingy about eligibility compared to other states’ programs (Bailey 2015). While Bailey calls expansion “a big policy step” for Virginia as a result of this historical stinginess (implying that this policy history makes enacting an expansion more difficult in Virginia than other states), Hanken (2015) says that this variable “cuts both ways.” While the stinginess of the existing program means “Virginia has a lot of catching up to do” in expanding coverage to the full population under 138 percent FPL, it also creates a greater incentive for expansion because the sum of the federal funds that would come into Virginia to cover such a large newly eligible population would be enormous (especially during the initial years when the federal government has promised to pay 100 percent of expansion costs).

Overall, Arizona’s history regarding Medicaid coverage made the context of the state’s expansion battle extremely unique. Many Arizona interviewees stressed this point and suggested that their state’s history was likely a key factor that allowed Arizona to achieve expansion
success while other states have failed. Coughlin (2015), for example, believes that this policy history was a fundamental aspect of the discussion of expansion in Arizona, and he does not believe the expansion effort would have been successful without this unique policy environment. However, other interviewees emphasize that Arizona’s unique health coverage history alone did not guarantee an easy path to expansion. According to Meaney (2015), without the large-scale advocacy effort from interest groups and the governor, the Proposition 204 mandate and history of funding the childless adult population would not have been enough to convince the legislature to approve an expansion. Therefore, although the trajectory of established state policy appears to be an extremely influential variable in determining the success of implementation in some contexts, the extent to which this variable is more or less powerful than interest group coalition composition and advocacy strategy in overcoming opposition to federal policy implementation is still unclear.

CONCLUSION, LESSONS, & FUTURE DIRECTIONS

Conclusion

Interest group leaders in both Virginia and Arizona invested enormous amounts of time and energy in lobbying efforts to push their state legislatures to implement Medicaid expansions, and the coalitions in both states mounted impressive and powerful pro-expansion campaigns. Yet several clear differences between the two states in interest group coalition composition and advocacy strategy appear to offer substantial insight into why Arizona was ultimately the more successful of the two states in overcoming opposition to federal policy implementation.

This project’s hypothesis posits that when interest group coalitions inclusive of and led by non-traditional policy allies execute well-funded and coordinated direct and grassroots
lobbying campaigns, they can cause state-level implementation of federal policy to proceed effectively even in the face of strong, organized opposition. Overall, the results of this study support this hypothesis. Pro-expansion interest groups in Arizona came together in a single, cohesive coalition that included both traditional and non-traditional policy allies but was led by non-traditional allies. This coalition was incredibly well funded and coordinated, and it engaged in an enormous campaign for expansion that involved both direct and grassroots lobbying strategies.

In Virginia, however, the major coalition (Healthcare for All Virginians) was led by and predominantly composed of traditional policy allies. Some non-traditional policy allies did advocate for expansion separately from the HAV coalition, but this split appears to have detracted from the coordination and ultimate success of the advocacy effort. In addition, funding for the pro-expansion campaign overall was very limited, and some interviewees express that grassroots mobilizing was a weakness of the Virginia expansion campaign (partially as a result of the dearth of funding). Certain members of the HAV coalition focused their efforts on grassroots mobilizing, but the major non-traditional allies that advocated for expansion separately focused primarily on direct lobbying strategies and did almost no grassroots lobbying on this issue at all.

Although there are some clear weaknesses of the interest group mobilization and advocacy effort in Virginia as compared to that in Arizona, it is important to acknowledge several additional variables that may also explain the discrepancy in state implementation success. The three most important of these variables appear to be the leadership and political party of the governor, the degree of gerrymandering of state legislative districts, and state past policy history. Expansion proponents in Arizona had the advantage of a supportive Republican
governor, as well as a health care policy history that in many ways aided the pro-expansion messaging and advocacy strategy. Virginia groups, on the other hand, had the disadvantage of heavily gerrymandered districts (as well as a speaker of the House whose unusually powerful position enabled him to maintain strict party cohesion).

Given these factors, it is impossible to say for certain whether Virginia would have been able to successfully implement an expansion had interest groups mobilized in exactly the same way that Arizona groups did. There is a chance that even an ideal interest group coalition that was impeccably well coordinated, well funded, and deeply engaged in both direct and grassroots lobbying would still have failed to facilitate a Medicaid expansion in Virginia. This research does demonstrate, however, that in some contexts (such as in the Arizona Medicaid restoration battle), interest group coalition composition and lobbying strategy can be the difference between success and failure in overcoming partisan opposition to implement federal policy. While interest group activity was not the only important factor, most Arizona interviewees emphasize that Medicaid expansion would not have been possible in their state without the massive and powerful interest group advocacy campaign.

The following sections will explore the broader implications of these results. They will highlight multiple potential lessons for interest groups, state government actors, and the national government, and discuss the generalizability of these results beyond the health care policy realm. A final section will propose multiple directions for future research into approaches to facilitating federal policy implementation in partisan, polarized state contexts.

**Lessons for Interest Groups & State Government Actors**

This research is highly informative for interest groups and state government actors seeking to foster smooth implementation of federal policy in contentious contexts. One of the
most fundamental lessons to these parties is about the importance of interest group coalition composition. Broad-based coalitions that are led by non-traditional policy allies appear to be more successful than coalitions led by traditional policy allies (and composed of a narrower group of interests) in overcoming powerful opposition to implementation. Coalitions composed largely of and led by non-traditional allies not only challenge skeptical actors’ preconceived notions about a policy (which are often based on nothing more than mere partisanship), but they also are better situated to provide political cover and support to legislators, governors, and other actors who are willing to take the risk of “crossing party lines” to back implementation. This type of advantageous coalition composition may be even more essential to implementation success in contexts where the governor’s political party puts them at a disadvantage in fighting for legislative support for implementation. In these situations (e.g. when Democratic Governor McAuliffe fights for expansion in a state with a Republican-dominated legislature), coalitions composed of and led by groups that are non-traditional policy allies may be able to defuse some of the partisanship and demonstrate that implementation is supported by a much broader community than just politicians from the party typically affiliated with the policy.

So given these suggestions about the characteristics of an ideal coalition, how can interest groups and state government actors actually create such a coalition? Interest groups can begin this process by either taking on the task of mobilizing/organizing a wide variety of groups (and especially non-traditional allies) to support implementation themselves, or by hiring outside actors to do this job (Arizona groups took the second approach by hiring two powerful consultants—Chuck Coughlin and Peter Burns—to fuse the pro-expansion Restoring Arizona coalition). Bringing organizations representing a wide field of interests into the coalition initially, however, is only the very beginning of the process of constructing an implementation campaign.
Next, the coalition needs influential non-traditional allies to visibly lead the initiative in a manner that is obvious to all observers. Two primary actors, both of which were non-traditional allies of Medicaid expansion, shared this role in Arizona: Governor Brewer (and her administration) and the Arizona Chamber of Commerce. Governor Brewer was instrumental in demanding interest groups’ commitment to advocacy, and her office took the lead in coordinating the direct lobbying strategy. Her role suggests that governors may be in a position to catalyze interest group mobilization (either before or after a coalition is first formed). As such powerful actors in state-level politics, governors may be highly capable of soliciting, incentivizing, and/or compelling the mobilization of a wide range of interest groups (especially, perhaps, when the governor him/herself is a non-traditional rather than a traditional policy ally). Furthermore, a strong partnership (involving great coordination) between the governor and the interest group coalition throughout the battle over implementation may be vital to success in overcoming organized, powerful opposition.

In Arizona, the Chamber took charge of the grassroots and “external affairs” aspect of the expansion campaign (Smith 2015). The Chamber employed leaders like Jaime Molera and Brittney Kaufmann to solicit, collect, and allocate funds, organize the various groups around a central goal, execute a sophisticated social media strategy, and run the effort like a campaign for political office. So while (depending on the scale of the effort) it may be helpful to have multiple leaders that can share the labor, it is critical that these leaders are unified under a single coalition and maintain a high degree of coordination with one another. It is also essential to keep in mind that regardless of the approach to coalition building and mobilization, this must all take place in a timely manner in order to avoid the many ramifications of a delayed or slow-moving implementation campaign.
While both Governor Brewer and the Arizona Chamber were extremely capable of taking on this leadership role, it may be more difficult in some contexts to identify and activate non-traditional allies to lead an implementation campaign. For instance, what if a state’s chamber or other well-positioned, non-traditional allies are not resource-rich or politically sophisticated enough to effectively carry out this leadership role? In these situations, building an effective coalition may require deft maneuvering behind the scenes by traditional ally groups. If traditional ally groups are aware of the need for an organized interest group coalition campaign for implementation but recognize that they are not in a position to be an influential visible leader of the initiative (due to their public image, partisan leaning, historical involvement in the policy at issue, etc.), they may be able to facilitate the leadership of less qualified non-traditional allies. For instance, affluent or powerful traditional allies may be able to provide weaker non-traditional allies with funds to invest in polling, hire campaign strategists, launch a strong social media campaign, or organize rallies/other advocacy events. The traditional ally groups may also be helpful by providing the non-traditional ally leader with information and expertise on running this kind of large-scale coalition effort—they may help the group in the visible leadership position develop a strategic advocacy plan for the coalition’s initiative (which would ideally include both direct and grassroots lobbying approaches). In taking this strategic approach of guiding from behind the scenes rather than directly, visibly leading the coalition, the traditional ally leader may be more effective at neutralizing some of the partisanship and increasing the probability of smooth policy implementation in the face of partisan opposition.

Interest group coordination, both between groups and with other implementation advocates (such as supportive governors or legislators), is another factor that this research highlights as crucial to fostering implementation success. While synchronization behind the
scenes is certainly necessary, more visible coordination appears to be incredibly important as well. Effective coordination does not just entail working behind closed doors with other implementation advocates to ensure that messaging and advocacy strategies are not in conflict. If interest groups hope to maximize their influence and achieve implementation success in the face of powerful opposition, implementation advocates of all varieties must come together to advocate as a team and speak with one united voice (perhaps through the use of shared talking points) in a manner that is obvious to all observers. The image of so many disparate groups working together towards a common goal can be immensely powerful, and so it is essential that this teamwork be noticeable and emphasized.

With regard to messaging tactics, this comparative case study suggests that framing an implementation initiative as a unique, state-specific initiative that is almost unrelated to the federal policy itself can be essential in an effort to implement a stigmatized or unpopular federal policy. Arizona was able to frame the expansion initiative as a “restoration” because of its unique policy history regarding the previous voter-mandated coverage expansion and the subsequent enrollment freeze. Yet even if a state does not have this type of useful policy history, implementation advocates may still be able to use semantics to their advantage and invent a way to define the initiative as a state-specific or state-unique effort. For example, rather than talking about a “Medicaid expansion” (which too obviously connotes supporting a large government program (Medicaid) and the widely unpopular Affordable Care Act), Virginia and other states struggling to expand might benefit from rewording or reframing the policy issue around state-specific programs or the state-specific purpose of implementation.

With regard to advocacy strategy, this study suggests that the combination of a direct and grassroots lobbying approach is more successful than a single strategy alone in overcoming
opposition to federal policy implementation. Virginia interest groups focused primarily on direct lobbying, with some key policy allies (e.g. VHHA and the state and local chambers of commerce) engaging in little or no grassroots lobbying at all (at least in the years before the end of the 2015 General Assembly session). Restoring Arizona groups, however, were heavily involved in both direct and grassroots lobbying, and this combination of strategies appears to have been key to the success of the campaign. Rather than simply telling legislators that implementation was the right decision and pressuring them to support it, the pro-expansion effort in Arizona was focused largely on providing political cover to legislators willing to vote for implementation despite the risk of political backlash. Within the legislature, the Restoring Arizona team sought to provide political cover by isolating the “fringe elements in the Republican party who were most vocal about…their opposition” and maintaining the backing of the supportive community (Coughlin 2015). With regard to grassroots strategies, Restoring Arizona’s mobilization of the public, sophisticated media campaign, and attainment of large amounts of polling data (among other efforts) seems to have allowed pro-expansion legislators to effectively demonstrate the legitimacy of and widespread support for their position. This political cover-oriented approach appears to have been successful at counteracting some of the partisan opposition, yet the effective provision of political cover was only possible through the combination of direct and grassroots lobbying tactics.

**Lessons for the Federal Government**

Although the results of this study indicate that it may often be best for the federal government (and specifically, the president) to avoid visible involvement in state-level policy implementation efforts, the federal government still may be able to help push implementation forward in contentious contexts through various actions (often conducted behind the scenes).
A first constructive role for the national government involves setting limits on the flexibility allowed to states in devising state-specific implementation plans. While this study suggests that interest group coalitions led by non-traditional policy allies may be most effective at overcoming opposition to federal policy implementation in states, there is also a danger that these coalitions will deviate significantly from the policy’s intended goals in their implementation plans (which are often resistant to change in future years). A business-led coalition, for example, may push a state to implement a federal program in a manner that significantly benefits the business community but neglects consumers or other interests that the federal program is intended to service. It is up to the federal government, therefore, to define the policy implementation field in a way that guarantees the retention of the federal policy’s most fundamental elements. In the case of implementation of the Medicaid expansion provision of the ACA, the federal government did this by promptly announcing that it would not approve partial expansion plans that extend coverage to less than the full population under 138 percent FPL. By firmly sticking to this rule, the federal government ensured that even conservative pro-expansion groups working in conservative states would be forced to fight for implementation plans that were in line with the ACA’s goal of extending coverage to this entire population.

The federal government may also be able to play a role behind the scenes in mobilizing and organizing interest group coalitions to effectively drive state-level policy implementation forward. In seeking to provide this support, the federal government must tread extremely carefully, especially in contexts where the federal government (and/or the president specifically) is generally unpopular and negatively associated with a federal policy. Any visible interference of President Obama or his administration in conservative states’ Medicaid expansion battles, for example, would likely only have fueled the opposition by confirming their claims that expansion
represented an unwanted intrusion of “Obamacare” into their conservative states. Yet it may be possible for the federal government to support implementation efforts by providing strategic advice and expertise to certain carefully selected interest groups.

The group(s) chosen for this partnership must not only be in favor of policy implementation—they should also be traditional policy allies that observers would likely expect to be supportive of the national government, the president, and the president’s policy goals. By working with and through this type of group, the federal government can make their involvement as inconspicuous as possible and have more confidence in the group’s unswerving support and cooperation. In the case of Medicaid expansion, working through a group like the Virginia Poverty Law Center might be a better choice than attempting to work through the Virginia Chamber of Commerce (rumors of national government interaction with the Chamber around this issue might raise major red flags for interest groups, legislators, and other observers/actors). A Republican president/presidential administration fighting to implement a conservative policy, however, might be well positioned to work through chambers of commerce or other typically right-leaning groups (depending on the details of the federal policy).

The decision about which federal officials, specifically, are assigned to spearhead this collaboration with state-level interest groups appears highly important as well. Individuals who are direct advisors to the president or clearly linked to the Obama administration, for example, might arouse suspicions if word gets out about their involvement with state-level interest groups, whereas federal officials with a greater degree of separation from the president who might be from less well-known departments may be better able to conceal the federal government’s involvement.
After reaching out to the selected group(s), federal government officials may be able to support the implementation process in multiple key ways. A first useful federal role may be to offer strategic advice to the partner group about how to organize a coalition that will be best suited to facilitate smooth implementation. This advice may incorporate the recommendation that the partner group (along with other traditional policy allies) play a behind the scenes role in the coalition while encouraging non-traditional allies to take on the visible leadership role(s). Federal government advice may also include suggestions on how to ensure a high degree of coordination between a wide variety of groups and how to advocate effectively (through messaging, direct/grassroots lobbying strategies, etc.) for the implementation goal. The inclination of state or local groups may be to focus only on lobbying approaches that they believe are likely to achieve success in their specific state. While this attention to the individuality of each state context is imperative, the national government might be able to contribute a valuable perspective on advocacy strategies that have or have not proven successful in states across the country. An awareness of the successful aspects of the campaign for expansion in Arizona, for example, may prompt the federal government to recommend that other states build coalitions that are led by conservative-leaning groups like chambers of commerce and composed of both these types of non-traditional allies and public interest-oriented groups.

Additionally, though a significant infusion of funds might be overly conspicuous and risky, the federal government may be able to use its resources in a supportive manner in other indirect ways (perhaps by commissioning polls that interest groups can use in the development of an effective messaging strategy, for example). But again, the potential hazards of every action that the national government takes in these contexts must be carefully considered beforehand to
ensure that the action will not backfire and undermine the advocacy efforts of other policy proponents.

Future Directions

While the results of this study reveal multiple interesting and significant insights into the process of overcoming partisan opposition to federal policy implementation, they also suggest many important directions for future research on this topic. The states included in this study were carefully selected to control for the effects of many additional (and potentially influential) variables, yet the results indicate that future research can be even more thorough in this regard. For example, future research on interest group roles in policy implementation should control for the party of the governor (rather than just whether the governor is an implementation proponent or opponent) and variation in state policy history (the discrepancy in Medicaid coverage history between Arizona and Virginia made it difficult to isolate the importance of the interest group independent variables in this study).

In addition, future studies should explore the significance of the interest group coalition composition and advocacy strategy variables across all (or at least in a greater number of) states with Republican legislatures where there is significant opposition to expansion. And more broadly, future research should investigate the validity of these findings regarding interest group coalition composition and advocacy strategy in implementation battles over non-health care policies (including policies that are Republican-led or conservative in nature).

Despite Restoring Arizona’s focus on grassroots advocacy, large segments of the public in Arizona still did not comprehend or were unaware of the Medicaid restoration/expansion issue. Future research, therefore, is needed to investigate how to improve the efficacy of large-scale interest group education initiatives on complex issues. There is also room to further clarify
the extent to which education of the public is essential to implementation success in contentious contexts—should this be a lower priority than other advocacy strategies for coalitions with limited resources?

The preceding sections on lessons for state government officials, interest groups, and the national government propose multiple potentially useful strategies for these actors that require further examination. One such proposal is the idea that even in contexts where the president is unpopular, national government officials can effectively support interest group mobilization by quietly working through a partner organization: providing the organization with advice on how to formulate a powerful coalition, offering a nation-wide perspective on effective lobbying tactics, and/or contributing polling data/messaging suggestions. A second proposal requiring additional research is the suggestion that in situations where there is not a resource-rich, politically sophisticated non-traditional policy ally that is willing to take on a leadership role in an implementation-focused coalition, traditional policy allies that have these capabilities can work behind the scenes to facilitate the leadership of a less qualified non-traditional ally. While this project’s results suggest that approaches like those listed above might be effective in fostering successful implementation in contentious contexts, future research is necessary to confirm whether these tactics actually work in practice.

Much research also remains to be done on the role of a number of variables aside from interest group mobilization. With regard to the role of governors, future studies should explore the significance of the governor’s political party, his/her overall relationship with legislators on both sides of the aisle, and his/her policy history and reputation. This research also suggests that it is advantageous to frame state-level implementation goals as distinct from a divisive national policy. Arizona groups were able to do this easily due to the state’s history of expanding
coverage to a larger segment of the population (this allowed for the framing of implementation as a “restoration” rather than an “expansion” of coverage), but future research should explore how this messaging tactic can be employed in states that have little or no past experience with policies similar to the one in question. Additional variables of potential significance illuminated by this research include proximity of the implementation process to national and state-level elections, the influence of gerrymandering on the effectiveness of interest group advocacy, and the timing of interest group mobilization/advocacy campaigns. Future studies should not only isolate these variables to determine their degree of influence alone, but also seek to compare their significance to that of the independent variables studied in this project: interest group coalition composition and advocacy strategy.
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Introduction


**Literature Review**


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**National Background Section**


Virginia Background Section


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Arizona Background Section


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Results/Discussion Sections (Non-Interview Sources)


The Business Case for a Medicaid Private Option in Virginia. The Virginia Chamber of Commerce.
APPENDIX


AARP Virginia
American Assn. of University Women of Virginia
American Cancer Society – Cancer Action Network
American Heart Association
Arlington County
Arlington Free Clinic
Blue Ridge Independent Living Center
Boehringer Ingelheim Pharmaceuticals
Bon Secours Virginia
Brain Injury Assn. of Virginia
Celebrate Healthcare
Central Virginia Health Services
Chesapeake Care, Inc.
CHIP of Virginia
City of Alexandria
Cornerstones, Inc.
Coverage Counts
Delta Sigma Theta Sorority, Inc. Virginia Beach Alumnae Chapter
Endeponence Center
FACETS
Fan Free Clinic
Free Clinic of the New River Valley
Gloucester-Mathews Free Clinic
Greene Care Clinic
H.E.A.L.T.H. NOW, Virginia
HealthWorks for Northern Virginia
Hemophilia Assn. of the Capital Area
Inova Health System
Instructive Visiting Nurse Assn. (IVNA)
Jewish Community Relations Council of Greater Washington
League of Women Voters of Virginia
League of Women Voters, Richmond Metro Area (LMV-RMA)
Legal Aid Justice Center
Legislative Coalition of Virginia Nurses
Mental Health America of Virginia
Mental Health America – New River Valley
National Alliance on Mental Illness of Virginia
National Assn. of Social Workers – Virginia Chapter
National MS Society – Virginia Chapters
National Osteoporosis Awareness Health (NOAH) Project USA
National Physicians Alliance – Virginia
Nonprofit Virginia
Northern Virginia Family Service
NOVA ScriptsCentral
Nueva Vida
Otsuka America Pharmaceuticals, Inc.
Patient Services, Inc.
Parents as Teachers State Office
Partnership for People with Disabilities at VCU
Piedmont Access to Health Services, Inc. (PATHS)
Piedmont Regional Dental Clinic
Planned Parenthood Advocates of Virginia
Prevent Child Abuse Hampton Roads
Prevent Child Abuse Virginia
ProgressVA
Rappahannock Legal Services, Inc.
Rappahannock United Way, Inc.
Richmond Orthopedics
Rx Partnership
SEIU – Virginia 512
Social Action Linking Together (SALT)
The Commonwealth Institute for Fiscal Analysis
The ARC of Virginia
VCU – American Medical Student Association
Virginia Adult Day Health Services Association
Virginia AFL-CIO
Virginia Assn. of Area Agencies on Aging
Virginia Assn. of Centers for Independent Living
Virginia Assn. of Community Psychiatric Nurses
Virginia Assn. of Community Services Boards
Virginia Assn. of Free and Charitable Clinics
Virginia Breast Cancer Foundation
Virginia Chapter of Doctors for America
Virginia Chapter, National Organization for Women
Virginia Civic Engagement Table
Virginia Coalition of Latino Organizations (VACOLAO)
Virginia Coalition to End Homelessness
Virginia Community Healthcare Association
Virginia Consumer Voices for Healthcare
Virginia Council of Nurse Practitioners
Virginia Elder Rights Coalition
Virginia First Cities
Virginia Health Care Foundation
Virginia Hemophilia Foundation
Virginia Interfaith Center for Public Policy
Virginia Latina Advocacy Network
Virginia March of Dimes
Virginia Medical Legal Partnership
Virginia Network of Private Providers
Virginia New Majority
Virginia Oral Health Coalition
Virginia Organizations Responding to AIDS (VORA)
Virginia Organizing
Virginia Podiatric Medical Association
Virginia Poverty Law Center
Virginia Public Health Association
Virginia Retired Teachers Association
Virginia Rural Health Association
Voices for Virginia’s Children
Volunteers of America Chesapeake

Restoring Arizona Supporters (restoringarizona.com):