The Politics Expansion Makes:

Analyzing the Political Returns and Policy Framing of the ACA's Medicaid Expansion in the States

by

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ABSTRACT

The 2010 U.S. health reforms expanded health insurance access to millions of Americans, mainly through an unprecedented expansion of Medicaid eligibility to those with low incomes. Not all states chose to expand their programs, resulting in disparate health-benefit access nationally. This study uses quantitative and qualitative analyses to explore the state-level politics of welfare policy expansion, focusing on the shifting nature of political support and rhetoric around beneficial social policy in the states following the implementation of Medicaid expansion. A key question is whether program expansion translated to greater electoral support for the Democratic Party as the party responsible for health reform. Another considers how pro-expansion advocates framed the issue of Medicaid expansion and built interest-group coalitions supporting recent statewide ballot initiatives. Findings point to negligible rewards for Democratic candidates, conditional on favorable state-level partisanship, and surprisingly broad-based penalties for Republicans from expanded Medicaid coverage. Furthermore, a content-analysis of pro-expansion campaigns in Oregon, Utah, and Maine finds successful issue-framing tailored to these states' unique and very different partisan-political context resulted in all three adopting (or readopting) Medicaid expansion. Framing in more conservative contexts, specifically of expansion's beneficiaries and policy rationale, managed to challenge and overcome longstanding anti-social welfare ideologies in Utah and Maine. Thus successful pro-expansion advocacy aligned rhetoric with a state's political values while directly engaging opposition ideas and arguments vis-à-vis the public. Finally, a protective policy discourse and robust coalition-formation in Oregon suggest the onset of considerable policy consolidation in existing expansion-states with strong progressive traditions.

Keywords: Policy feedbacks, Medicaid expansion, political parties, policy framing, policy advocacy, partisanship, welfare state politics

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> "Unresolved struggles from the era of the New Deal…inform the generationally oriented political strategies of conservatives and progressives today."
>
> – Theda Skocpol, *Social Policy in the United States, 1995*

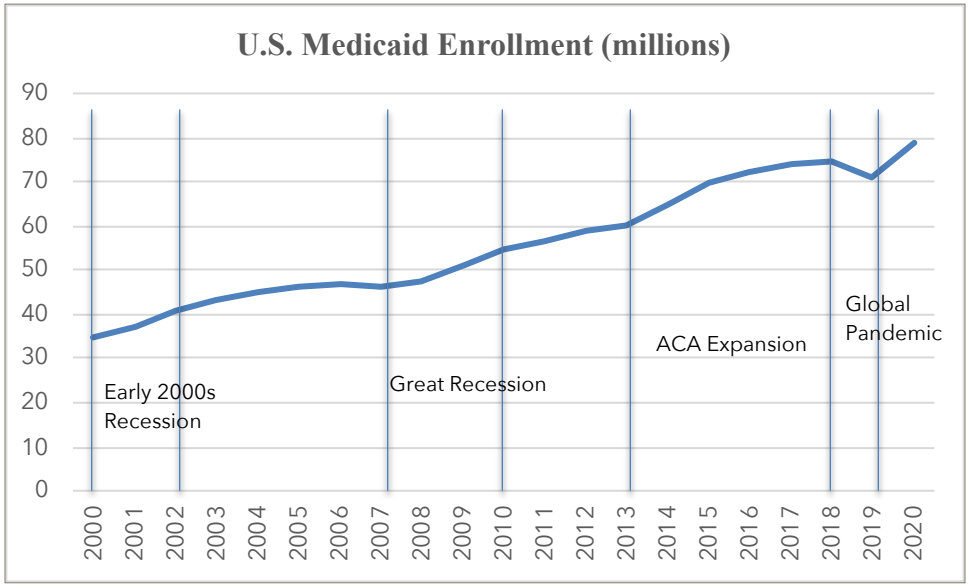
INTRODUCTION

More than a decade ago, the Patient Protection and Affordable Care Act (ACA) precipitated sweeping reforms to the U.S. healthcare system, simultaneously vaulting it to the center of U.S. politics. Since its passage, health reform has become the subject of endlessly intense controversy and political contestation. One of these controversial reforms was the federal expansion of Medicaid – the joint federal and state public health insurance program for low-income and disabled Americans – to millions more low-income, childless adults. Redefining federal eligibility to include non-disabled persons near poverty was unprecedented in the program's history, resulting in almost 16 million newly insured Americans (CMS, 2020). Apart from the reform's substantial material improvements is a broader question regarding the political implications of drastically expanding social protections and their potential for shaping a new politics of social welfare in its wake.

Born in the Great Society of the 1960s and reserved for the neediest in society, Medicaid has since become a lower-middle-class entitlement serving at any one time around 73 million people before the global pandemic (CMS, 2020). National program enrollment has steadily risen over the lifetime of the program. Since 2000, the program has witnessed several expansionary periods that were either structural (i.e., economic) or policy-based (i.e., legislative) in nature (see Figure 1). Expanded eligibility for Medicaid officially began in 2014 leading to a roughly 4-year period of expansion driven mainly by participating

expansion-states. Despite – or perhaps in spite of – long-sought conservative efforts to retrench the program, most recently in an unsuccessful bid by a Republican-controlled Congress to "repeal and replace" the ACA, a majority of Americans now view the social program favorably and much less stigmatizing than in years past (Grogan & Park, 2017).

Figure 1
National Medicaid enrollment, 2000-2018



Source: Kaiser Family Foundation

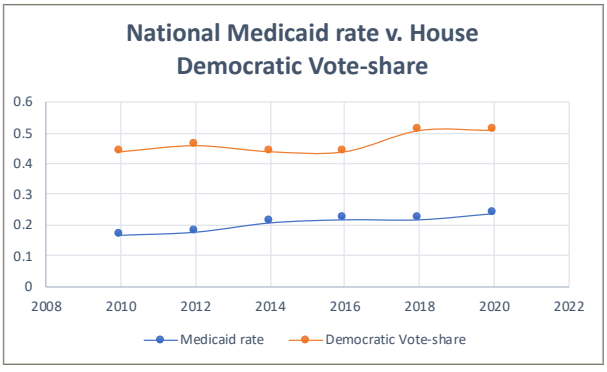
As views of the ACA have polarized along partisan lines, an equally polarizing effect has occurred for program eligibility and access across the country. While upholding most of the health law's constitutionality, the U.S. Supreme Court, in its 2012 ruling in *National Federation of Independent Business v. Sebelius*, declared the ACA's Medicaid expansion optional for the states. States could not be federally mandated to accept federal funding to expand their programs. Predictably, more liberal, Democratic-led states opted overwhelmingly to expand their programs while 12 of the most conservative, Republican-led states still refuse to do so. This study takes the partisan-institutional divide that has emerged

in the wake of the court's decision as an opportunity to interrogate the distinctive partisan state politics shaping voter appreciation and policy advocacy for expansionary welfare policies.

Medicaid expansion set in motion a cascade of state-level policy decisions, most consequential of which was the decision of several states *not* to reform their programs by refusing expansion take-up altogether. But while expansion states now face the task of financing recent accelerations in program enrollment, in several non-expansion states, political leaders' refusal to expand their state programs has been met with growing resistance. This emergent political dynamic is the primary focus of this study. Specifically, how fundamental electoral realities in each state and reformist advocacy pressures associated with Medicaid expansion interact with state partisan-institutional contexts to promote (or hinder) expansion program development and resiliency over time.

What follows is a mixed-methods analysis of the electoral and advocacy effects of Medicaid expansion and its implications for different state political contexts. In particular, there is a question of political rewards from expansionary Medicaid policy and whether the Democratic Party has benefited electorally from recent coverage gains (see Figure 2). Further exploration of state-level pro-expansion advocacy combines with the electoral analysis for insights from advocates' chosen rhetorical strategies and the challenges and opportunities they faced in

Figure 2
Medicaid enrollment and House Democratic vote-share, 2010-2020



attaining (or retaining) expansionary reforms within distinctive state-level partisan-institutional contexts. Both quantitative and qualitative empirical approaches guide separate inquiries into the state-level implications of expanded Medicaid coverage for political party support and pro-expansion advocacy dynamics.

The study seeks to address the "pre-event" policy advocacy strategies and "post-event" political feedback of Medicaid expansion in the states. Tying these separate investigations together is a theoretical proposition holding that, once enacted, beneficial social policies trigger positive feedback effects which serve to sustain the initial policy and may even ensure its resilience against future policy retrenchment (see Pierson, 1996, 2000). Federal program expansion set off successive 'ripples' of feedback in different, but related, political processes. First, within state-level Medicaid policy advocacy, as reform proponents faced challenges and opportunities from public perceptions of the program's purposes and the new constituencies made eligible in the wake of nationwide expansion; and second, in the political returns, or strengthening, of parties and interest groups supporting expansion once reform has been won in the state legislature or at the ballot box.

Thus the study aims to investigate three related research questions: whether Democrats received electoral benefits for Medicaid expansion; what arguments pro-reform advocates used to make their case for Medicaid expansion in their state, in particular, whether and to what extent they used rights-based appeals; which groups were involved in these state-level pro-expansion coalitions and what was their relationship to each other and the expansion issue. The first of these questions is tested via regression analysis using state-level panel data, while a qualitative case study analysis assesses the second and third

questions. Partisanship is given special attention throughout for its role in shaping any observed policy feedback processes.

The following section provides a cursory treatment of Medicaid's origins, history of recent expansions, and federal program expansion under the ACA. This is followed by a discussion of the welfare state literature on the feedback processes which give rise to social welfare policies' resiliency over time. A methods section then describes the study's design elements, with findings presented and discussed in-depth. Finally, study findings are interpreted in light of both the extant literature and the current state of Medicaid expansion politics in the US.

MEDICAID POLICY HISTORY

Origins, Resilience and Early Expansions

For such a consequential program today, it is ironic that Medicaid was considered somewhat of a legislative afterthought at its inception (Smith & Moore, 2008; Olsen, 2010; McDonough, 2012). Meant in part as a strategic backstop against future public insurance expansions by some conservatives – by siloing a potential new program constituency – Medicaid's steady enrollment growth ever since has defied early expectations of a contained, politically weak program (Smith and Moore, 2008; Olsen, 2010). Medicaid's relative "institutional stickiness" – once embedded in state budgets – and its broad buy-in from influential health industry groups would fuel this growth and ultimately prove to be a significant source of political resiliency (Pierson, 2000; Thompson, 2012).

Policymakers initially designed Medicaid to be an "open-ended" federal commitment, mandating states to accept all eligible and offer essential services without spending caps, with bans on enrollment caps and waiting lists (Thompson, 2012). Initially, federal mandates to cover categorical groups restricted state program eligibility to AFDC ("welfare") recipients and the aged, blind and disabled – a linkage which would give rise to the epithet "welfare medicine." Despite these limitations, states found Medicaid an effective means of substituting federal- for state-financing of social services (e.g., setting lower eligibility standards and broadening available services to maximize the flow of federal matching funds). States would continue to seek opportunities to leverage federal funds and challenge national policy advances aimed at reining in their steady flow. By the 1980s, however, this resiliency

would face its first serious challenge in a resurgent conservatism that would set the stage for decades of retrenchment politics to come (Olsen, 2010).

President Reagan's administration fired the opening salvo of the new era when it proposed curtailing Medicaid costs via "block-grant" reform, an annual spending cap for states which would have effectively ended the program's entitlement status. The proposal threatened to decimate state budgets. In response, Republican and Democratic state governors alike, alongside hospitals and other providers who stood to lose significant funding under the new policy, mobilized against the administration's onslaught (Slessarev, 1988; Olsen, 2010). Together with a robust bipartisan congressional coalition of liberal Democrats and moderate Republicans, these cross-coalitional pressures managed to rebuff the first serious retrenchment attempt (Slessarev, 1988).

Block-grant reform would re-emerge as a policy idea again during the Clinton and George W. Bush presidencies, only to fail legislatively in both cases. The first instance saw a new coalition of Republican state governors, allied with Speaker Gingrich, pushing for the block grant as a solution to frustrating federal constraints, growing fiscal pressure on state budgets, and perceived working-class resentment (Slessarev, 1988; Thompson, 2012; Olsen, 2010). However, near-unanimous opposition from Democratic governors, congressional Democrats, and the president himself, in addition to shifts in public opinion against perceived Medicaid cuts, successfully blocked these reforms. For the first time, the episode pointed to political benefits from defending Medicaid for national Democrats and risks for Republicans from making overt appeals to program cuts (Thompson, 2012).

Out of these retrenchment periods, basic program structures and prerogatives would emerge firmly intact (Slessarev, 1988; Thompson, 2012; Olsen, 2010), while reforms of another kind continued apace, including coverage expansions to new groups of beneficiaries. Welfare reform's ending of automatic entitlement to health care benefits for AFDC recipients – essentially de-linking Medicaid from the welfare system – initiated a gradual process of remaking the program's public image of primarily serving welfare recipients helping low-income families more broadly (Thompson, 2012; Olsen, 2010). In 1997, the new Children's Health Insurance Program (CHIP) provided states additional funds for insuring children on a family income basis. Moreover, many states, including Minnesota and New York, would obtain federal waivers for coverage expansions to "nontraditional" categories of need, such as non-disabled, childless adults (Thompson, 2012). These early state-level expansions to low-income, childless adults would become the national health reform model's Medicaid expansion years later.

2010 Healthcare Reform

The 2008 election opened up a political window of opportunity for policy change unlike any arguably since the Great Society. Having captured both Congressional branches and the presidency – including a filibuster-proof Senate majority – the Democratic Party, under President Obama, set out to comprehensively reform the nation's health care system. Instead of systematic transformation, however, the administration and its congressional allies decided on a path to universal coverage through reforms of the existing health policy infrastructure. Lessons from past failures of even more ambitious legislation – most notably

President Clinton's 1994 Health Security Act – and the ideological makeup of the Democratic conference at the time figured prominently in this political calculus. From the start, the administration pursued a social strategy of "co-optation" of health care industry interests, many of whom had been staunch opponents of past reform efforts. Beyond its perceived political feasibility, the strategy also hinged on a theory of entrenched interests that, once sufficiently embedded in a new regulatory and fiscal regime, would become committed stakeholders, insuring reform against future retrenchment (McDonough, 2012; Skocpol, 2010).

Although the same political cleavages that had vexed past reform efforts would reassert themselves once again, policy strategy and political circumstances would produce different results. Higher levels of partisanship meant state governors divided along partisan and ideological lines, effectively neutralizing their influence as a block; they mustered but a vague practically-minded consensus declaring their opposition to "unfunded mandates" and "cost-shifting to states" (McDonough, 2012, p. 138). Health industry groups – recognizing Democrats' determination for reform and the new political reality – became especially active in the legislative process, preferring to shape reform than being shaped by it (Skocpol, 2010). What eventually emerged was an unprecedented federal regulatory regime for health insurers and health care providers, alongside a new system of insurance subsidies and coverage mandates.

While the Medicaid expansion provision – which increased federal financial support to states to expand their programs – drew some of the strongest Republican rebukes over reform, Democratic defenses or promotion of it during its early stages are noticeably hard to

come by in the congressional record (McDonough, 2012). Notwithstanding the imbalance in partisan saliency, the new policy represented a significant change from almost exclusively categorically-based eligibility to national uniform income-based eligibility and standards of coverage. Individuals without regard to disability or family status (e.g., child, parent, pregnant mother, etc.) earning up to 138% of the federal poverty level could qualify for health benefits.

Moreover, the ACA's “essential health benefits” standards of coverage meant an additional qualitative expansion in health care services. Through greater uniformity and federal discretion, expansion architects believed that a more “nationalized” program could become influential in shaping future US health system transformations (McDonough, 2012). This expansion and enhanced nationalization of the US healthcare system would potentially create feedback loops, which would further entrench and shield it from retrenchment. The following section surveys the academic literature that explains why policy feedback loops lead to institutional resilience.

LITERATURE REVIEW

Policy Feedback Theory

Policy feedback is the process by which public policy comes to define the political environment by shaping individual and group political behavior in ways that lead to subsequent changes in political institutions and policy outcomes. The guiding question of the field concerns how and under what conditions "new policies create new politics" (Schattschneider, 1935). Once established, public policies can reinforce themselves over time by shaping the capacities, interests, and beliefs of political actors, generating entrenched constituencies and norms which sustain the policy politically (Pierson, 1993, 1994; Campbell, 2012). In this view, policies reshape state capacities and the attitudes of mass publics and the political goals and capabilities of social groups (Skocpol, 1992). Prior policy accomplishments can set in motion "changing policy agendas and alternative possible alliances" of subsequent policymaking cycles, "jointedly conditioned" by a state's institutions and newly emergent social relationships (Weir, Orloff, & Skocpol, 1988, p. 17). Thus the fate of a policy becomes a function of both prevailing institutional arrangements and the relative attachment and enhanced capacities of social group interests.

Feedback processes are facilitated primarily through resource (material/participatory) and interpretive (symbolic/rhetorical) effects (Mettler & SoRelle, 2017). Resource effects occur when the economic or social gains of policy for certain groups induce support for its continuation, presumably out of self-interest. Social actors become "interests" insofar as they "are people and organizations who have a stake in an issue or are affected by it," updating prior commitments and beliefs in the process (Stone, 2002). Such malleability of social

policy preferences exists for various changing material circumstances (Alesina et al., 2011; Owens & Pedulla, 2014). The effect inevitably creates "dense interest-group networks and strong popular attachment" to the policy and the politicians willing to support them (Pierson 1996, p. 146). This new constituency – of interest groups, voters, policymakers, and others – will seek to defend, and if possible extend, the policy's original prerogatives to safeguard social gains.

Interpretive – or ideational and symbolic – effects of a policy compound total feedback by influencing the public's perceptions of the intended target group (Beland, 2010). Whether a group is perceived to be socially deserving of benefits can affect the level of public concern, and attendant policymaking accorded different groups in society. Differentiating social groups along a continuum of deservingness in policy discourse can affect eventual policy access, benefit generosity, and eligibility, which can alternately empower or stigmatize policy recipients. Rhetoric – as a strategic device – signals a target group's relative deservingness to the public by reinforcing or reshaping existing social perceptions to achieve policy success or defeat (Schneider & Ingram, 1993). In other words, "Americans reach political decisions on matters of policy," according to Nelson and Kinder (1996), "as if they had first determined the moral qualifications of the intended beneficiaries" (p.1071). Thus, problematizing social welfare issues to mass publics is instrumental to these prospects and depends considerably upon predominant social welfare ideologies in the political environment and political actors' capacity to negotiate their terms rhetorically.

Social welfare programs represent both settled and ongoing contests over the redistribution of societal resources, and the social rights and citizenship access to such

resources bestows (Marshall, 1950). Different policy regimes – or the distinct constellation of public policies according to desired social goals – structure social rights and citizenship differently, which subsequently affects citizens' status in society (Esping-Anderson, 1990). Scholars emphasize that the kind of public social provision – universal or selective – affects public perceptions of deservingness in advanced industrial societies and, in turn, the nature of conflict over and level of public support for social welfare policies (Skocpol, 1995; Larsen, 2008).

Universal social benefits are typically popularly supported because they serve larger constituencies and emphasize common social security over redistribution. On the other hand, means-tested services tend to help smaller, disadvantaged constituencies, creating hostility between beneficiaries and the contributing public, especially the non-eligible working classes (Skocpol, 1995; Jordan, 2013; Mettler & SoRelle, 2017). Compared to its Western European counterparts, the United States has historically taken a "residual," as opposed to universal, approach to social service-provision, preferring to target select social groups (e.g., those who are poor) over broader constituencies (Esping-Anderson, 1990). The current study explores the nature and extent of the response by mass publics and interest groups – in terms of political support and rhetorical frames – to an evolving means-tested social program whose benefits have suddenly become more widespread (i.e., more universal).

Political Effects of Reform

Contemporary policy feedback research reveals meaningful political impacts from beneficial social policy broadly and, most recently, from expanded health benefits under the

ACA. For example, those who tangibly benefited from the ACA's marketplace subsidies or expanded Medicaid were more likely to hold a favorable view of the law's impact regardless of partisan-affiliation, with higher ratings coming from non-white and Democratic voters (Jacobs & Mettler, 2018; Hopkins & Parish, 2018). Medicaid expansion is positively associated with immediate increases in voter registration and turnout in the next election (Clinton & Sances, 2018; Baicker & Finkelstein, 2018), but also voting drop-offs and political "demobilization" stemming from program stigma and local administration (Michener, 2017, 2018). Moreover, dual-political effects may be at work with higher voter turnout attributed to new beneficiaries and backlash-voters opposed to the law and its implementation (Haselswerdt, 2017).

Parties that legislate beneficial social policy may also see political returns for doing so. For instance, disaster relief has engendered long-term returns in political support for the incumbent party responsible (Bechtel & Hainmueller, 2011); however, in some cases, effective support may partly rely on the partisan "match" of voter and representative (Chen 2013). More recent scholarship has found increased approval for state governors following decisions to expand their state's Medicaid programs, mainly from Obama-supporters and those in states where the Medicaid population is more likely to be white (Fording & Patton, 2019). Health coverage increases were associated with higher Democratic-presidential vote share in 2016, coming entirely at the expense of the Republican candidate; though, and related to this study, a state's Medicaid expansion status did not significantly affect vote shares for either candidate (Hollingsworth et al., 2019).

Scholars also note how "politics competes with policy feedback" via partisan filtering of resource (self-interest) effects and other feedback mechanisms (Jacobs & Mettler 2018, p. 347). But the results of several studies on this front are decidedly mixed. For instance, Hopkins and Parish (2018) find that ACA favorability ratings among Democrats receiving expanded Medicaid coverage do not significantly differ from Republicans of similar socioeconomic circumstances. Nor does party identification alone necessarily mute feedback effects of individual assessments of the ACA's policy successes; only once 'sociotropic' evaluations are accounted for do these differ (Jacobs & Mettler 2018). However, beliefs about the ACA's long-run impact significantly differ among partisans, with negative prospections among Republicans at all income-levels likely attributed to "motivated reasoning" (Chattopadhyay, 2018). Moreover, a governor's partisanship and the composition of a state's legislature substantially drive decisions to expand Medicaid (Barilleaux & Rainey, 2014). This preeminence of politics over real social need is notably most pronounced for Southern hold-out states (Travis et al., 2016).

The Rhetoric of Reform

Framing plays an integral part in policy change by affecting the political viability of new policies and programs in the process of building public support. Durability does not result exclusively from entrenched social interests, but also the use of "effective collective symbols to legitimate the social policies" on offer (Skocpol, 1988, p. 307). In practice, this takes the form of framing, which seeks to overcome socio-political constraints by directing public attention toward certain aspects of an issue and away from others, in effect defining

problems and identifying remedies which shift the terms of debate onto favorable terrain (Entman, 1993). For example, early New Deal rhetoric's abandonment of collective solidarity for a more instrumentalist view of reform arguably undercut its social and moral dimensions ensuring a more problematic legacy (Holt, 1975). Individualist political traditions have since endured as a relentless challenge to contemporary universalist social policymaking.

More recently, Skocpol (1996) identified the unwieldiness of President Clinton's health reform and proponents' focus on universal "security" as a rhetorical strategy as key reasons for its demise. These opened the plan up to multi-frontal attacks invoking "big government" intrusion that exacerbated already growing anxiety among different constituencies (particularly the working and middle classes) about changes to the status quo. Proponents' decision not to directly engage opponents' arguments and to pursue exclusive framing as a policy strategy likely cost health reformers some public support (Jerit, 2008). Thus effective framing likely includes some kind of rebuttal or preemption of the other side's arguments in addition to selective framing of the issue in proponents' favored terms. Recent scholarship has noted the advantages of such a context-specific engagement strategy over framing for shifting elite political attitudes (Karch & Rosenthal, 2017).

Ideas of deservingness and the purpose of social welfare are a significant aspect of the dominant framing in contemporary U.S. social politics (Watkins-Hayes and Kovalsky, 2016; Weir, Orloff, and Skocpol, 1988; Nelson and Kinder, 1996). Within this deservingness frame are two opposing schools of thought whose problem-definitions often imply conflicting policy solutions. Individualists, seeing social problems as arising from personal deficiencies, consequently seek to promote greater personal responsibility. Structuralists find the causes of

social ills in existing economic, social, and political conditions and call for collective action in response (Watkins-Hayes and Kovalsky, 2016). Both frames attempt to activate deep-seated group-centric attitudes that effectively mediate public preferences concerning governmental aid for poor and low-income groups (Nelson and Kinder, 1996; Applebaum, 2001; Slothuus, 2007; Rose and Baumgartner, 2013). But by the 1980s and '90s, a neoliberal 'welfare consensus' had emerged, privileging an individualist conception of poverty's causes that has structured social policy debates ever since (Brady, 2009, 2016; Barany, 2016; Rank, 2016). Other scholars have noted the 'racialization' of welfare issues (i.e., the linking of race and welfare by opponents) since the Great Society as a leading factor explaining anemic, under-resourced social policy in the U.S. today (Quadagno, 1994; Winter, 2008; Metzl, 2019). Such deservingness frames have figured prominently in the public discourse over U.S. health reform and Medicaid expansion in particular.

No single issue frame defines pro-ACA advocacy rhetoric. These frames essentially cast deservingness in terms of external forces to be secured against while foregrounding those individual qualities which most accrue public approval. Before the ACA's passage, presidential arguments for reform emphasized costs and market-efficiencies before becoming more rights-oriented after passage (Leimbigler and Lammert, 2016). An analysis of Congressional Democratic debate speeches revealed 'need' as the predominant pro-reform issue-frame more than rights, deservingness, or entitlement (Beechey, 2015). Democratic rhetoric also featured an omnipresent "nurturing" paternalist frame of protecting the vulnerable from the market's vicissitudes and corporate villainy during the legislative push for the ACA (Hilberg, 2015; Marshall, 2017). Moreover, the preponderance of media

portrayals at the time cast ACA beneficiaries as workers, emphasizing themes of workforce participation and economic self-sufficiency while paying little attention to health status, age, gender, race/ethnicity, or other alternative political argumentation (Chattopadhyay, 2015).

ACA opponents, by contrast, based their debate-framing around a language of costs, tax-burdens, and negative economic impact borne by reform (Marshall, 2017). Those few conservative Governors who did expand Medicaid appealed to the deservingness of the working poor, positive state economic and financial impacts, and faith and morality (Rozier and Singer, 2016; Arguelles, 2019). Since then, conservative discourse and policymaking has tried to curb Medicaid expansion's reach by redefining benefit deservingness around work. State waiver processes –which allow for federally-approved reforms of state programs – have most recently become vehicles for conservative reforms imposing cost-sharing and work requirements. Through a rhetoric of personal responsibility, these reformers frequently invoke the image of "able-bodied adults" as a means of undercutting the perceived deservingness of newly-eligible beneficiaries (Grogan et al., 2017; Jarlenski, 2017; Ku and Brantley, 2017). A key question of this study is whether liberal pro-expansion advocates have similarly evolved their framing strategies towards further inclusivity of newly-eligible beneficiaries.

The next section examines quantitatively whether Democrats reaped political rewards for Medicaid expansion by looking specifically at how changing program coverage rates effect electoral support. A subsequent qualitative analysis examines how different rhetorical frames were used to achieve Medicaid expansion in three very politically different states.

This final analysis also addresses the political circumstances giving rise to state expansion coalitions.

DATA, METHODS AND FINDINGS

A Panel Analysis of U.S. States

The following panel analysis concerns political party returns from Medicaid expansion over a definite period. The study considers the effects for both of the two major parties. The section immediately following discusses briefly the data and methodological decisions followed by a presentation of findings.

Data

I collected data for several variables of interest and select controls to study the effects of changing state Medicaid coverage differentials for congressional Democratic Party political support in six congressional general elections over the 2010-2018 period. The sample is fully balanced (i.e., all states have measurements in all periods), fixed panel data set of 50 states observed over five periods for a total of 250 observations. The unit of analysis is US states due to limitations in the availability and retrieval of more granular, countywide data.

Outcome Variables. Democratic Party support measures total Democratic Party vote share in U.S. House races. Vote share measures as the proportion of state-wide votes cast for all congressional Democratic candidates in an election. Variable data comes from biannual election statistics available in the online archives of the U.S. House of Representatives.

Covariates. Medicaid expansion measures the proportion of a state's population covered by the state's Medicaid program taken as an annual average. Where average enrollment data was unavailable, the estimate took the average of April, July, and October

enrollments for the year. I collected Medicaid enrollment data from the Centers for Medicaid and Medicare's (CMS) online monthly state Medicaid enrollment reports.

State partisanship data comes from The Cook Political Report's "Partisan Voting Index," or PVI score, which measures the relative strength of a state's partisan political preference against the nation as a whole. Score calculations compare the major-party vote share (i.e., the party winning the most votes) of a geographic unit to the nationwide average across the two most recent presidential elections (Wasserman & Flinn, 2017). Negative scores indicate a greater Republican-lean, and positive scores a greater Democratic-lean. The PVI scores function as a loose proxy and control for state political culture. A partisan interaction term (P.I.T.) combining the variable for state Medicaid coverage rate and partisanship (PVI) tests the interactive effects of partisanship on party vote share at varying state Medicaid program coverage levels.

Lastly, I included several controls for state-level population and political characteristics like race/ethnicity, income, poverty, unemployment, sex, voter turnout, and population density. Table 1 below presents the changes in means of covariates and outcome variables over time. Mean differences measure the change in variable values for the entire period of study. The 2018 election represents an outlier in the total observed variation in party vote share across panels and subsequently considered for model specification decisions in the following section.

Table 1
Means of outcome variables and covariates, 2010-2018

	2010	2012	2014	2016	2018	Δ 10'-18'
Outcome Variables						
Democratic Vote Share [0–100]	44	46	44	44	51	6.59**
GOP Vote Share [0–100]	53.73	50	52	52	47.21	-5.52*
Covariates						
Medicaid Insurance Rate [0–100]	17	18	21	22	22	5.0***
Partisan Voting Index (PVI)	-2.44	-2.58	-2.58	-3.45	-3.45	1.00
Percent of State Black [0–100]	9.98	9.99	10.12	10.14	10.20	0.22
Percent of State Hispanic [0–100]	10.62	10.98	11.34	11.68	12.07	1.45
Percent of State Asian/Pacific Islander [0–100]	3.69	3.85	4.00	4.15	4.30	0.61
Voter Turnout [0–100]	44	60	40	62	52	8.0***
State Median Income ($10k)	4.99	5.17	5.50	5.89	6.12	1.13***
State Unemployment Rate [0–100]	8.76	7.30	5.76	4.64	3.78	4.98***
Percent in Poverty [0–100]	14.68	15.16	14.81	13.52	12.85	1.83*
Population Density, 1k per sq. mi	164.46	166.19	167.74	169.12	170.35	5.89
Sex Ratio (m/f)	97.48	97.57	97.66	97.81	97.86	0.38
N	250					

Note: Difference between the two years is statistically significant with *p < .05, **p < .01, ***p < .001

Methodology

A random-effects model with panel-corrected standard errors was used to test the effects of Medicaid coverage rates and partisanship on party vote share. I excluded fixed

effects and opted for random effects because a Hausman test determined the coefficients for different specifications were consistent with each other. Fisher unit-root test for non-stationarity confirmed stationarity in the dependent variable and all main independent variables of interest, reducing the likelihood that spurious correlation is driving my results. Although the inclusion of a lag of Democratic Party vote share significantly correlated with later-period vote shares, it was ultimately excluded from the model once first-order serial correlation was detected. The final model did include (n-1) time dummies to account for omitted time shocks present for each election year. I utilized panel corrected standard errors as an LR test indicated that heteroskedasticity was present. Failure to account for this would lead to understated standard errors (and optimistic variable significance). The result is the following panel regression equation:

$$\text{Party Vote Share}_{ist} = \alpha + \beta\,(\text{Medicaid rate}_s) + \gamma\,(\text{PVI}_s) + \delta\,(\text{Partisan Interaction}_s) + \lambda\,(\text{year dummy}_t) + \text{Controls}_s + \epsilon_{ist}$$

Findings

Table 2 shows results for a levels panel-estimation of the effects of Medicaid coverage rates on party vote shares and their interaction with state partisanship. The first model is the baseline model, while the second model includes a partisan interaction term (P.I.T.). Graphical representations give the predictive and marginal effects of Medicaid insurance rates on party vote share relative to state partisanship produced by the levels-estimator.

Table 2

Regression results of Medicaid coverage effects on state-level party vote share and voter turnout using levels estimators, 2010-2018

	Democratic Vote Share		**GOP Vote Share**	
Covariates	Baseline	+ P.I.T.	Baseline	+ P.I.T.
Medicaid Insurance Rate [0–100]	0.03 (0.06)	0.09* (0.06)	-0.16** (0.06)	-0.26*** (0.06)
Partisan Voting Index (PVI)	0.99*** (0.08)	0.60*** (0.00)	-1.00*** (0.09)	-0.38** (0.13)
Medicaid x PVI	-	0.02** (0.00)	-	-0.03*** (0.01)
Percent of State Black [0–100]	0.25*** (0.03)	0.23*** (0.03)	-0.28*** (0.02)	-0.25*** (0.02)
Percent of State Hispanic [0–100]	0.09*** (0.02)	0.11*** (0.02)	-0.15*** (0.03)	-0.18*** (0.04)
Percent of State Asian/Pacific Islander [0–100]	0.09* (0.06)	0.00* (0.06)	-0.24** (0.08)	-0.10† (0.06)
State Median Income ($10k)	3.82*** (0.65)	3.28*** (0.71)	-5.89*** (0.97)	-5.03*** (0.95)
Percent in Poverty [0–100]	0.90*** (0.20)	0.86*** (0.22)	-1.09** (0.31)	-1.01** (0.30)
State Unemployment Rate [0–100]	-0.33* (0.17)	-0.13 (0.19)	0.36† (0.21)	0.03 (0.21)
Population Density, 1k per sq. mi	0.00** (0.00)	0.00 (0.00)	-0.00** (0.00)	0.00 (0.00)
Sex Ratio (m/f)	-0.43** (0.13)	-0.39** (0.12)	0.37** (0.11)	0.43*** (0.10)
Voter Turnout [0–100]	0.02 (0.07)	0.08 (0.06)	-0.11 (0.09)	-0.02 (0.07)
2012	0.35 (1.24)	-0.24 (1.07)	-2.53 (1.58)	-1.58 (0.63)

2014	-2.77*** (0.74)	-1.96* (0.86)	3.85*** (0.95)	2.56** (0.92)
2016	-2.15 (1.57)	-2.31 (1.47)	0.38 (1.91)	0.64 (1.84)
2018	-3.12** (1.19)	3.88** (1.36)	-0.31 (1.51)	-1.53 (1.61)
Constant	45.98*** (13.86)	44.60*** (13.80)	50.53*** (11.67)	52.73*** (9.71)
R-squared	0.875	0.882	0.859	0.876
N	250			

Notes: Author's calculations based on election data from the House of Representative's Clerk of the House Elections Statistics (2010–2018), MIT's Election Data Lab "U.S. House 1976–2018," state economic and demographic data from the U.S. Census's American Community Survey 2010–2018 (1-Year Estimates) and Bureau of Labor Statistics, and state medicaid data from the Centers for Medicare and Medicaid Services and Kaiser Family Foundation.

† p < .10, * p < .05, ** p < .01, ***p < .001

State Medicaid insurance rates are generally not significantly associated with vote shares for Democratic candidates, but rather are mediated by the degree of state partisanship. Republican vote shares, on the other hand, show a significant negative association with moderating effects from state partisanship. Although the main effect remains nonsignificant in the Democratic case, state partisanship tends to mediate vote share increases at least somewhat. Coverage rates, being significantly negatively correlated with lower vote shares in the main effect, are compounded (or abated) by relative state partisanship for Republicans. A one percentage point increase in the state coverage rate is associated with a .16 percentage point decrease in Republican vote shares, where any positive gains (as anticipated) fail to materialize for Democrats more generally, though the situation is different under favorable partisan conditions.

Both parties benefit from increasing state partisanship levels in their respective partisan directions, as indicated by the partisan interaction term's positive association (i.e.,

"partisan premium"). So while parties may (or may not in the Democrats' case) see an initial gain (penalty) for every percentage point increase in a state's Medicaid coverage rate, a state's relative partisan-lean will either slightly augment or mitigate this gain (penalty) at successive levels of partisanship. Thus Democrats do tend to benefit, but these gains are strictly conditioned on the relative partisan-lean (i.e., higher levels of liberal/Democratic partisan voting) of the state. The average Republican-leaning state (PVI = -10.2) could see Republican vote shares increase by .31 percentage points (-.03 x -10.2), where the main penalty is offset by successive gains in increasingly favorable partisan electorates. By contrast, the average Democratic-leaning state (PVI = 6.4) could see Democratic vote shares increase by an additional .19 percentage points (.03 x 6.4), where gains remain *dependent* upon the specific partisan composition of a state's electorate (i.e., there is no observable effect otherwise).

The associated effect size of Medicaid coverage on party vote share is of a small-to-medium magnitude for both parties (Cohen, 1988). The corresponding rise and decline of Democratic and Republican vote shares in 2018 in Table 1 raises the question of whether this year in particular drives most of the association between coverage rates and party vote shares for the period. Dropping these observations from the model does not change the associational significance of variables in either the main or interaction model specifications. Moreover, it is not entirely clear what could account for the discrepancy in electoral outcomes (i.e., no main effect for Democrats, yet substantial, robust effects for Republicans).

Vote-switching is an unlikely culprit given the unrealized Democratic gains to Republican base declines. One possibility is an expanding electorate due to enhanced civic

capacity (i.e., resource effects) among new beneficiaries, which would be consistent with the positive "partisan premium" both parties reap from their respective partisan electorates.

Moreover, where Republicans opt to expand Medicaid, a demoralizing effect could lead more ardently ideological partisans to "stay home" at election time in an apparent rebuke of the party. For instance, in Ohio and Arizona, Republican state leaders' expansion decisions jeopardized the support of some party members and activists who saw it as a "betrayal" of party ideals (Somashekhar, 2013; Hallet, 2013). Republicans may also be uniquely disadvantaged politically by potential positive impacts from visible, government policy, although it remains puzzling why Democrats would not also generally benefit for the same reason. It is possible that a portion of voters inclined to support Republicans do so on the premise of government's perceived inability or incapacity for improving their well-being, but may not participate once they see these needs being met. This idea is explored further in the discussion of political efficacy in the final section of the study.

Medicaid, partisanship and party vote shares.

Figure 3 below shows the relationship between a state's Medicaid coverage rate and Democratic vote share relative to a state's average partisanship based on results from the levels-estimation in Table 2. Partisanship's positive mediating effects on Democratic vote share are, unsurprisingly, most significant in more Democratic-leaning states. For the average Democratic-leaning state, a one-percentage-point increase in the Medicaid coverage rate correlates to a 1.3% increase (the line's slope) in Democratic vote share. The same one-percentage-point change in state coverage rate correlates to a .33% increase and -0.5% decrease in Democratic vote share for the average partisan-leaning and Republican-leaning

state, respectively. Thus Democratic vote share declines with increasing state Republican-partisanship.

Figure 3
Democratic vote share by Medicaid coverage rate and average state partisanship

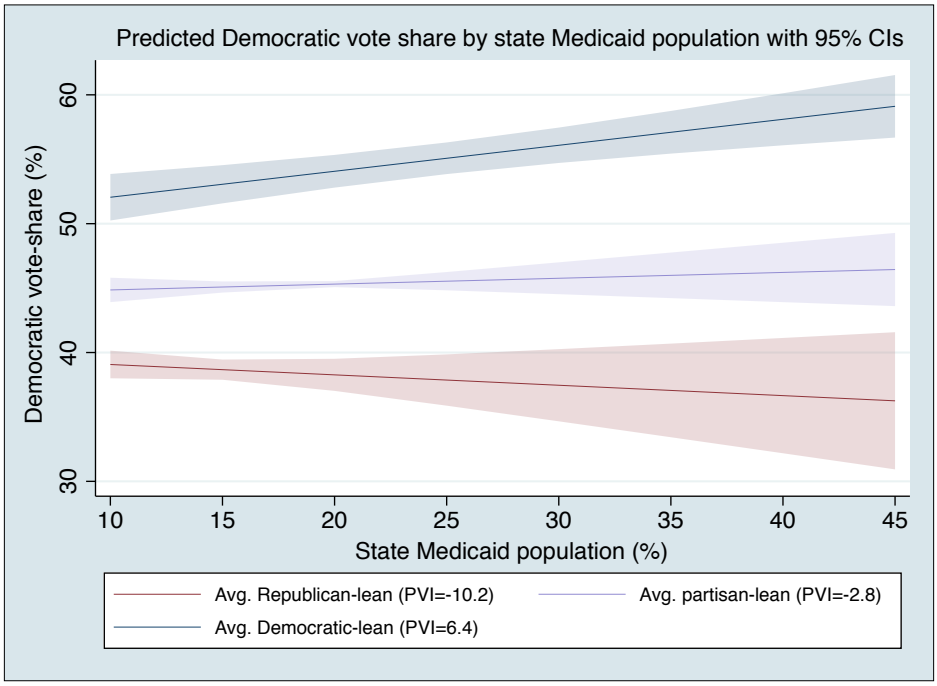


Figure 4 below depicts the average marginal rate of return of Medicaid coverage for Democratic vote share at varying state partisanship levels. The average marginal effect of an increase in the Medicaid coverage rate turns negative at a state PVI of -5.9. There are gradual diminishing returns to Democratic vote share at increasing state Republican-partisanship levels, eventually turning negative at a level of partisanship below the average (i.e., more conservative) for Republican-leaning states but above the average (i.e., more liberal) for all partisan-leaning states. Thus, vote share gains from Medicaid coverage expansion diminishes

with increasing state Republican-partisanship and may become costly to Democratic candidates at above-average state Republican-partisanship levels.

Figure 4
Average marginal effects of Medicaid coverage rate on Democratic vote share by state partisanship

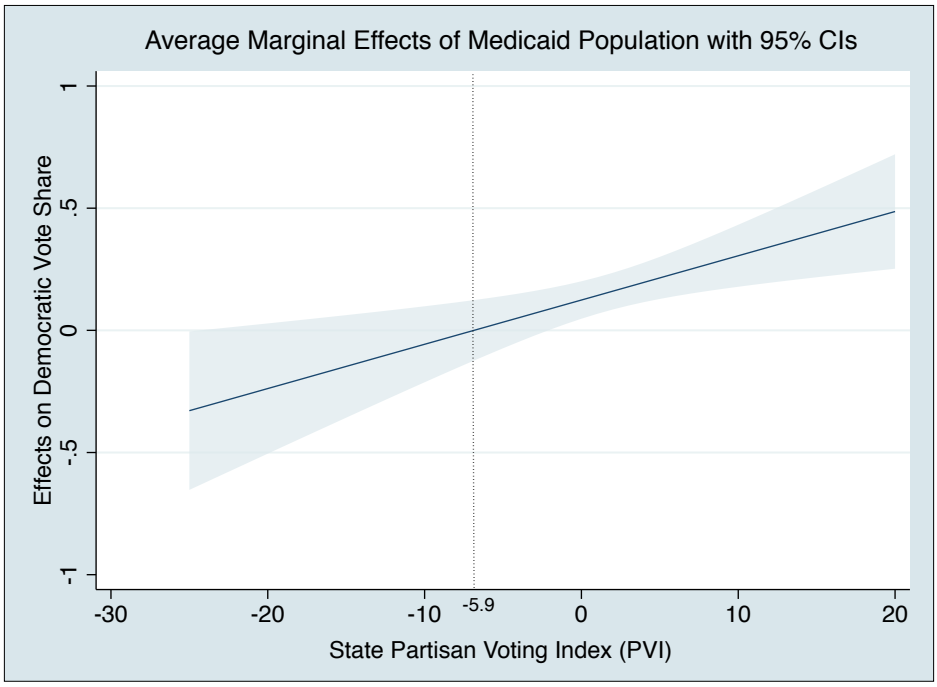
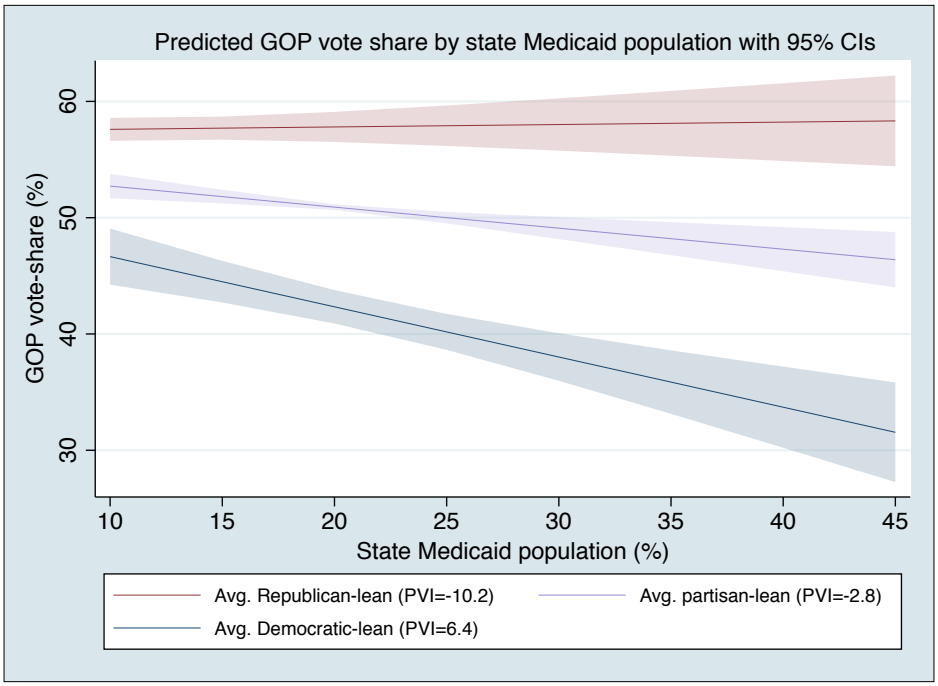


Figure 3 presents the marginal effects of Medicaid coverage rate increases for the Republican vote share. The coverage rate effects on vote share are negative at all average levels of state partisanship. The average marginal impact of a one-percentage-point increase in the Medicaid coverage rate correlates to a .37% decrease in Republican vote share in the intermediate Republican-leaning state. The effect's magnitude increases with increasing Democratic-partisanship, where the correlations are -1.3% and -2.5% for the average partisan-leaning and Democratic-leaning states, respectively. Republican vote share tends to see more significant penalties from Medicaid coverage increases at each successive level of

partisanship . But there is a partisan-inflection point at which a state's relative Republican-partisanship produces a positive marginal benefit to party vote share.

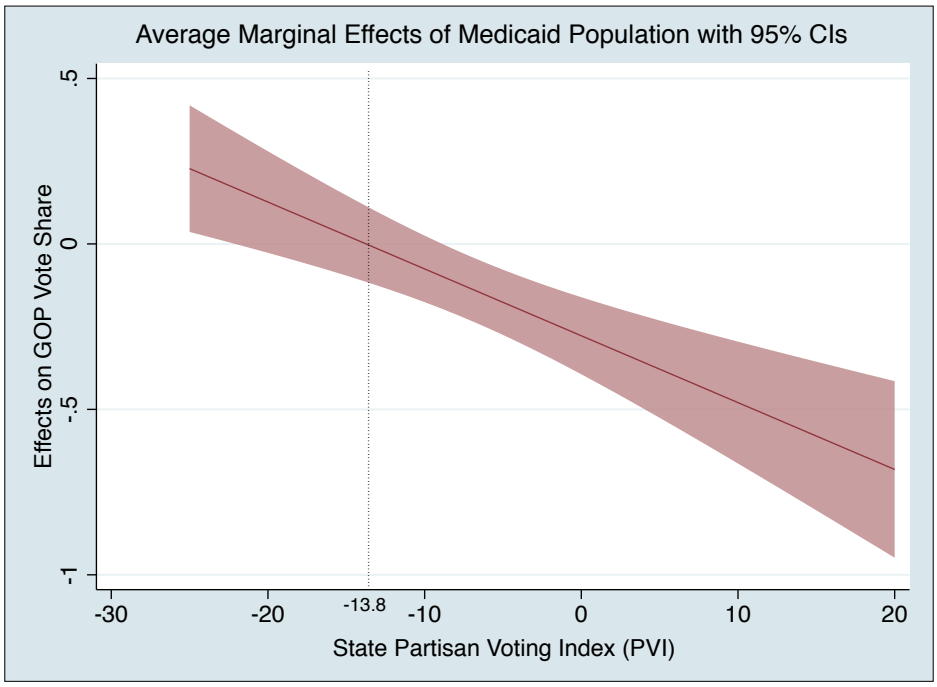
Figure 5
GOP vote share by Medicaid coverage rate and average state partisanship



According to Figure 4 above, Republican vote share sees positive returns at relatively high state Republican-partisanship levels. At a state PVI of -13.8, marginal effects become positive, indicating positive returns to party vote share from increases in the state Medicaid coverage rate. However, these positive marginal effects may not necessarily translate into net gains to Republican vote share because of the concurrent negative main impact of rate increases on vote share found in Table 1. Thus a positive moderating effect of Medicaid coverage expansion on Republican vote share only holds for state Republican-partisanship

levels substantially above the averages for both Republican-leaning states and partisan-states overall.

Figure 6
Average marginal effects of Medicaid coverage rate on GOP vote share by state partisanship



The next section of the analysis addresses the questions regarding political rhetoric and institutional support within Medicaid expansion advocacy. Of particular interest are the framing strategies of recent advocacy campaigns for Medicaid expansion and their interactions with the surrounding partisan-political landscape. Policy feedback, in this case, considers rhetoric and coalition formation not simply as products of their unique political environment but expansion policy itself and, to an extent, the residual impact of federal health reform where ACA coverage expansion has yet to be fully implemented.

An Analysis of Political Coalitions and Rhetoric in 3 State Case Studies

This section compares the rhetoric and politics of Medicaid expansion across three different states. I analyzed recent pro-expansion advocacy efforts to frame expansion and the obstacles and opportunities they faced building winning coalitions. In-depth state profiles showcase the contrasting issue-frames and coalition dynamics of individual advocacy campaigns.

Case Selection

Employing a method of agreement case study design – using Utah, Oregon, and Maine as cases – this section examines how rhetoric on statewide ballot measure campaigns led to the expansion of Medicaid in three states with radically different political ideology and political climates. I argue that the commonality that led to the same outcome in all three different cases (the passage of the statewide Medicaid expansion ballots) was effective campaign promotion around the state's political environment. The statewide campaigns that are studied are Maine's 2017 "Question 2" and Utah's 2018 "Proposition 3" ballot measures which expanded Medicaid for the first time in both states (whose governors or legislatures rejected Medicaid expansion), and Oregon's 2018 "Measure 101," which continued financing Medicaid expansion in the state. Table 4 below depicts each state's PVI score and history of party control of state government. Oregon fits the "Democratic" case, Utah the "Republican" case, and Maine the "Independent" case. Though the closeness of Oregon and Maine's respective PVI scores make any distinction seem trivial, their most recent electoral histories indicate a clear difference in state politics.

Table 4
Party control of state government, 2010 – 2018

State Government		2010	2012	2014	2016	2018
Oregon PVI: D+5	Governor	D	D	D	D	D
	Senate	D	D	D	D	D
	House	D	S	D	D	D
Maine PVI: D+3	Governor	D	R	R	R	R
	Senate	D	R	D	R	R
	House	D	R	D	D	D
Utah PVI: R+20	Governor	R	R	R	R	R
	Senate	R	R	R	R	R
	House	R	R	R	R	R

Source: ballotpedia.org

Oregon's electorate has consistently elected Democrats to statewide offices with few exceptions and increasing over the prior decade. Oregon's most recent PVI score of D+5 makes it slightly more Democratic-leaning than Maine and serves as the archetypal "liberal-Democratic" case in the study. By the time of the Supreme Court's *NFIB v. Sebelius* decision, state leadership had already resolved to pursue full expansion of the state's Medicaid program under the ACA. There was, however, a fiscal question regarding how the state would finance its portion of expansion costs once federal support began gradually tapering off after the first few years. This critical question of financing would arise during the 2017 legislative session and eventually become the basis of the 2018 Measure 101 ballot measure.

Maine's relatively middling state partisanship score is representative of its independent political streak. Cook Political Report puts the state's latest PVI score at just

D+3, a sharp departure of about 2 points from prior presidential election cycles coinciding with Donald Trump's election in 2016. Although the state has a slight Democratic partisan-lean, Maine's electorate has an established history of electing statewide officials from both major parties, including independents, unlike the other two states. For example, a politically moderate Republican and a popular former Independent governor hold the state's two U.S. Senate seats. As shown by Table 4, a history of fluctuating state government control between the two major parties can attest to this bi-partisan political tradition.

With a PVI score of R+20, Utah ranks as one the most conservative states in the nation per the Cook Political Report's 2017 Partisan Voter Index. Republicans have long dominated state politics in the state, giving Utah the longest-existing state government trifecta (i.e., single-party rule of all three branches of state government) since 1985. Advocates initially sought to expand Medicaid through the legislature. But after several failed attempts and the offer of out-of-state support from the Fairness Project, they moved to a statewide campaign.

Theory of the cases.

Guiding the analysis of state cases is the concept of state political culture, or the particular set of beliefs and deep-seated values underlying state political goals and institutional behaviors, which ultimately comprise a unique state polity (Fitzpatrick & Hero, 1987). Elazar's (1984) typology of political culture established a baseline for political-cultural analyses of the states by identifying three main state-types: moralistic, individualistic, and traditionalistic. The goal of the moralistic state polity is "to achieve the broadest good for the community" and espouses a view of government as a legitimate means

of correcting social inequities (Fitzpatrick & Hero, 1987, p. 148). In individualistic state polities, political goals are determined by public demands made within "a marketplace of ideas and actions," where political competition is strongest, making the outcomes of such debates "more variable in content" (Fitzpatrick & Hero, 1987, p. 151). Finally, the traditionalistic state polity is the most socially rigid and politically unyielding, seeking to "maintain the existing order," with less concern for the public welfare (Fitzpatrick & Hero, 1987, p. 148). Moralistic polities are most inclined toward policy innovation, or reformist tendencies, while traditionalistic polities are least innovative in this respect, with individualistic polities exhibiting moderate levels of innovation (Elazar, 1984; Fitzpatrick & Hero, 1987).

One hypothesis of this study is that a greater emphasis will be placed on rights-based appeals for health coverage expansion in more politically liberal environments. The researcher also expected that policy advocates in other states would utilize similar arguments to a lesser extent at decreasing levels of political liberalism. Thus, given its progressive political history, Oregon best presents as the "moralistic" case; Utah's culture would be more or less "traditionalistic" in orientation; while Maine would exhibit a more moderate individualism. Opposition rhetoric in each state should also be a helpful barometer for gauging the accuracy of these rough typologies. Of course, there will be many overlapping traits considering the closeness of Oregon's and Maine's partisanship scores. The latter's politically independent streak (see Table 4) gives it a closer approximation to traditionally conservative values despite a slight Democratic-partisan lean. Since it occupies the moderate

political center of the other two cases, Maine should share both rhetorical and institutional characteristics.

Data Collection and Coding

I first collected qualitative data for discerning the particular composition and characteristics of advocacy rhetoric in different state-political environments. I used text-based data retrieved from campaign literature, television advertisements, letters-to-the-editor, newspaper opinion-editorials, and social media content of official pro-expansion campaign Facebook and Twitter accounts and those of endorsing interest group organizations (as listed on each campaign's official website) that maintained an active online presence. I restricted the timeframe for data collection to material existing from a campaign's inception to the date of a ballot-measure election. I used an emergent thematic coding approach to identify common, recurrent phrases, words, and references within individual cases and grouped them according to overarching themes. I then compared differences in themes in rhetoric across cases.

Additional qualitative data meant to supplement the main content analysis sought out advocates directly involved in campaign operations and decision-making regarding coalition formation and chosen rhetorical strategy. A purposive sampling method applied outreach via email and social media (e.g., Linkedin) to identifying campaign operatives of past statewide campaigns in Oregon, Maine, and Utah. I made successful contact and conducted eight semi-structured interviews with advocates per the following breakdown: Oregon (5), Utah (2), and Maine (1).

A deeper investigation of interest group coalition dynamics illustrates how Medicaid expansion structures particular interests and alliances in favor of the policy's sustainment. Oregon's circumstance as the only case in which advocates defended Medicaid expansion against potential retrenchment offers a glimpse into how historically opposed groups can mobilize under a common interest of preserving a social policy. The coalition case study draws from four interviews conducted with political representatives from a hospital group, a labor union, a medical professional organization, and a coordinated care organization (CCO) involved in the "Yes on Measure 101" campaign. Interviews concerned the interest group's campaign role, the significance of Medicaid expansion to the interest group, and relations with other coalition partners before, during, and following the campaign.

I obtained a total of 1405 coded references from roughly 514 unique texts (including 432 social media posts, 58 newspaper articles, and 24 campaign videos). Coded references break down by case as follows: Oregon (607), Maine (391), and Utah (407). Table 5 below shows specific examples of statements, phrases, and words used to categorize thematic appeals. The list of examples for each category is by no means exhaustive but delineates the general ideas and sentiments which warrant inclusion in one category versus another.

Table 5
Select Examples of Thematic Code/Categorical References across Cases

Theme/Code	Definition	Illustrative Quotes
Economic/ Fiscal	Addresses economic efficiency and fiscal implications of expansion for individuals and the state	"*stabilizes premiums*" "*more federal funds…to pay for healthcare*" "*grows our economy and creates jobs*" "*decreased spending on uncompensated care*" "*reduce long-term healthcare costs*"

Vulnerable Populations	Expresses concern for elderly, indigent, children and other dependent social groups with greater care needs	"*the neediest among us*" "*the most vulnerable among us*" "*homeless veterans*" "*people who are struggling with medical conditions*" "*seniors, people with disabilities and at-risk children*" "*low-income families*"
Health	Appeals to the health impacts of expansion for individuals and state health systems (hospitals, care providers)	"*improve health outcomes*" "*provide needed healthcare*" "*healthier communities*" "*will save lives*" "*more people will get care that keeps them healthier*"
Institutional/ Expertise	Draws on the credibility of medical professionals, community organizations/institutions for political support	"*Doctors and Nurses…show their support*" "*members of the faith community standing up in support*" "*growing coalition of groups supporting*" "*small business owners… are endorsing*"
Solidarity	An appeal to communitarian values of caring for fellow citizens, recognition of common needs, and the social gains therein	"*contributing to the whole for the benefit of all*" "*everyone deserves peace of mind*" "*take care of our neighbors*" "*benefits everyone*" "*we all can do our part*" "*no one should have to*" "*nobody is immune to devastating illness*" "*fabric of our community*" "*basic/ human right*" "*benefit every man, woman, and child regardless of their current means*" "*caring for neighbors*"
Work/ Deserving	Portrayal of expansion beneficiaries as working people, and thus deserving of social benefits provided at community expense	"*hard-working*" "*working families*" "*we should reward hard work*" "*poorest workers and families*" "*low-income working people*" "*working poor*" "*busy working mom*" "*we work hard*"
Structural	Arguments attentive to the policy and institutional environment determining opportunities for health coverage	"*coverage gap*" "*low-paying jobs that don't offer coverage*" "*multiple part-time jobs*" "*fall through the cracks*" "*can't afford health insurance*"
Moral/ Equity	Broad-based appeals to fairness and a general sense of moral rightness	"*do what's morally right*" "*the right thing to do*" "*paying for people in other states*" "*to address inequality in health care*" "*finally right this…wrong*"
Progress	The promise of social progress or building upon progress already made; the sense of being a part of progress	"*continue our progress*" "*we cannot take a step backward*" "*something [to] be proud of*" "*brings us closer to ensuring*" "*our chance to guarantee healthcare*"
Bi/Non-Partisan	Appeals made to circumvent partisan loyalties by drawing attention to the cross-partisan nature and impact of health care issues	"*Republicans, Democrats, and independents*" "*people over politics*" "*bipartisan*" "*isn't about politics*"

Pro-Expansion Coalitions and Rhetoric

Each state case study provides insight into advocates' rhetorical strategies and coalition dynamics and the partisan-political factors shaping campaign opportunities. Rhetorical strategy is both a function of the peculiar political culture and the partisan context in which advocates operate. Profiles were constructed from an accounting of each state's distinct rhetorical emphases and provide the content analysis' general thrust. Moreover, as revealed by Oregon's experience, a state's health policy history can structure new coalitions' opportunities and composition to secure Medicaid expansion once established.

Pro-expansion advocates made several distinct appeals for Medicaid expansion in their state campaigns. These predominately fell along traditionally economic, health, and social-based lines of persuasion. Table 6 shows the distribution of rhetorical appeals made in each state case. Overall, fiscal arguments, concern for vulnerable social groups, health improvements, and appeals to expertise were most salient across all cases. However, the degree of appeal saliency – that is, its rhetorical composition – within each case reveals the nature of political rhetoric engaged in and its unique relationship to the partisan environment in which advocates were operating. I conducted a statistical test of significance for differences in appeal frequencies across cases for making comparative inferences. Highlighted in bold are themes for which references were significantly higher in one state than another.

Table 6
Thematic Code Frequencies, by Percent of Total Coded References across Cases

Theme/Code	Utah	Maine	Oregon	All
Economic/Fiscal	**27**[a]	**30**[a]	17[b]	24
Vulnerable Populations	15[a]	9[b]	**33**[c]	21
Health	11[a]	**17**[b]	6[c]	11
Institutional/Expertise	7[a]	6[a]	**16**[b]	10
Solidarity	8[a]	7[a]	11[a]	9
Work/Deservingness	**12**[a]	5[b]	6[b]	7
Structural/Poverty	**13**[a]	7[b]	2[c]	7
Moral/Equity	6[a]	5[a]	3[a]	5
Progress	1[a]	**4**[b]	**6**[b]	4
Bi/Nonpartisan	**4**[a]	**2**[a]	1[b]	2

Note. Bolded percentages indicate highest code-frequencies for a category. Percentages with different letter postscripts based on a Chi-square test of significance at $p < .05$ of a difference in code-frequencies across state-cases.

Advocates in Maine and Utah tended to a significant degree to emphasize economic arguments for expansion, whereas Oregon advocates emphasized protecting vulnerable groups. These decisions in part reflect each case's unique situations, where advocates in the former two cases were seeking expansion for the first time, while those in the latter case were seeking to protect an existing expansion program. Theme saliency likely reflects the particular state political-cultural and institutional context as well. For example, Utah

advocates made more structural-based arguments for Medicaid expansion, perhaps to preempt the skepticisms of an individualistic, conservative political culture. Moreover, Maine advocates employed more conventional health and economic appeals for a decidedly 'bread-and-butter' campaign. And in Oregon, while a logic of protecting vulnerable groups makes sense in the context of perceived social program cutbacks, the appeal's overwhelming presence, alongside a focus on expert credibility and communitarian language, nonetheless reflects the state's progressive political culture.

Solidarity in health care (i.e., the belief that health care is a human right and universal access to health care, regardless of social status or material means, should be a societal norm), though present, was not a central part of advocacy rhetoric. These appeals do not provide the predominant thrust of argumentation in any cases, composing barely more than one-tenth of overall rhetoric observed. Oregon advocates did utilize solidarity appeals slightly higher than advocates elsewhere, though not significantly so. However, its significance in Oregon's case has less to do with proportionality and more to do with incorporating communitarian ideas and language across rhetorical themes like economy and health.

Advocacy appeals mainly differ in degree as state advocates managed to draw from similar basic facts regarding expansion's impact and rationale. In this regard, a state's political environment substantially delimits a campaign's influence, including its rhetorical choice-sets. Rhetorical emphases, therefore, reflect the priorities and underlying political values of the state. Moreover, the institutional mix of political and organizational actors significantly shapes advocacy opportunities within state-specific political landscapes. Both

aspects of Medicaid expansion advocacy – rhetoric and coalition development – are analyzed in a rendering of the political dynamics advocates faced alongside a description of their chosen rhetorical strategies.

Oregon's Measure 101: Protecting the vulnerable. Oregon advocates pursued a rhetorical strategy with society's most vulnerable at its core. Advocates put those most disadvantaged by potential policy retrenchment at the forefront. They specifically elevated the health impact for vulnerable children in the state and the elderly, sick, and disabled should the measure have failed. They combined a concern for the vulnerable and validating Medicaid expansion's credibility by healthcare professionals and other community leaders. Interwoven throughout their messaging is a communitarian logic stressing the collective trade-offs of continued policy expansion and its harmful corollary, policy retrenchment, for Oregon communities.

Measure 101 opponents coalesced around an argument critiquing the financing measure on tax-equity grounds, calling for the legislature to go back to the drawing board (Hansen, 2017; Reschke, 2018). The opposition – led by the "Stop Healthcare Taxes" committee – while conceding the legitimacy of expansion, argued the taxes financing future expansion benefits were inequitably levied among health care providers and consumers. Moreover, they argued these taxes would be passed on to consumers in the form of higher health care and insurance costs.

Coalition dynamics. Of all the cases, Oregon advocates had the most favorable political climate and circumstances to advance expansionary Medicaid policy. Healthcare providers of all types–hospitals, CCOs, doctors, nurses, and medical professional

associations–were all supportive, even before the campaign began. These groups formed the political coalition that would make the initiative petition and subsequent ballot measure possible. "[It] was largely healthcare stakeholders, being hospitals and CCOs and some insurance companies, and then large organizations who represent a lot of working people– SEIU, and OEA, AFSCME," a campaign operative told me.

The state's Democratic governor and legislative leaders also supported Medicaid expansion as a matter of political course. The operative added that the state's Democratic Party grass-roots activists "were fired up because it was the first election post-Trump…and [they had] nothing to divide their attention." So, they were "invited to meetings…[and] did a bunch of work on behalf of the YES campaign [becoming] one of our most active endorsers." With broad buy-in from healthcare and nonprofit groups – a strong political base of support in the state – and an energetic party apparatus, advocates' pro-expansion campaign built up a formidable political capacity to rebut an increasingly defensive opposition and win expansion at the ballot box.

The coalition assembled to defend Measure 101 was unique in several key respects. Expansion offered a rare opportunity for, as one political representative put it, "strange bedfellows"– labor unions, progressive groups, hospitals, and healthcare providers – to come together on one side of an issue. Labor unions and hospitals fit this description exceptionally well because of their more traditional "adversarial" relationship "at the bargaining table," the representative said. Another union representative said hospitals were "the newest member to the coalition," alongside CCOs. Hospitals had voiced their displeasure with the new non-reimbursable provider tax included in the legislature's Medicaid funding package. Still, state

legislative leaders asked them to support the measures anyway, per a hospital representative close to the campaign. But hospitals also favored expanding the tax base supporting Medicaid by placing new insurers, CCOs, and others under the overall financing mechanism, which was also a part of the omnibus package.

The newly enacted provider taxes included, for the first time, rural hospitals and CCOs in the mix of providers expected to finance state Medicaid services. They would now have "skin in the game," as the hospital representative said. But the significance of the inclusion of rural hospitals, historically outside of the provider tax program, was in its political implications. The representative noted how rural hospitals had supported the funding package and Measure 101 and speculated that this support was likely validation for generally tax-skeptical voters in rural parts of the state. Moreover, securing this support made it more difficult for Measure 101 opponents to "split the hospitals" in effect on the expansion issue. A CCO representative involved in the campaign also noted that CCOs had never before been a part of the provider tax conversation but supported their new provider tax designation. The expansion funding package was a "big deal" to CCOs because of the fear of returning to the past of "picking and choosing" beneficiaries through a lottery-style system that had existed only a decade prior in the state. But the coalition's most significant aspect was the evolving partnership of arguably its two most prominent political players: labor unions and hospitals.

Both labor unions and hospitals brought considerable resources to the Measure 101 campaign. Hospitals were the single biggest funders of the effort, while unions brought a deep reservoir of resources in their membership and organizing capacities. Each came to the campaign for distinct reasons. The union representative indicated "what was at risk for our

members was this going backward on [healthcare as a right] that we had really committed to and that we believe in," while the political representative struck a similar tone of support from medical professionals that was "values-based…[and seen as] a moral imperative to make sure that people have health care." For the hospital group, the risk lay in shutting off a key revenue stream for providing mandated, essential health services to the public. Furthermore, legislative leaders signaled that the alternative could be worse in terms of rate cuts. Moreover, they surmised a partial reason underlying union-backing lay in a basic fear that Measure 101's failure posed a real risk to the state's general fund, the primary funding source for state public services.

Each of these groups also carried long-held pre-conceptions of the other informed by a history of industry and legislative confrontations over economic issues. "At the beginning, there was a bit of tension," the union representative admitted. Their general impression was that industry groups could "make a lot of assumptions about what our mindset is around the work we do." In particular, that labor unions are "very self-interested." For their part, the hospital representative suggested that a mischaracterization of hospital profitability may have driven – more than was warranted – changes in provider-tax policy in the final Medicaid funding package and that unions were the foremost advocates for this change in the legislature. There also seemed to be a lack of a "shared language from the beginning," stemming from the fact that hospital groups were less "accustomed to campaigns, let alone progressive campaigns." These initial impressions, however challenging, would eventually transform into something more constructive as the campaign progressed.

While working together, the groups reported observing a change in perceptions of the other. “Once we got into it,” the union representative explained, “there was a mind shift about who the other person was that broke down a lot of stereotypes.” They also noted how the hospital industry group “actually saw us for the first time as a value add…as strategic thinkers.” Moreover, according to the hospital representative, what made the two groups “natural allies” was their shared worldview about Medicaid funding. Both groups perceived this shared campaign experience as beneficial to the relationship. “We always think [an issue/ event] will be the turning point when we can have a different relationship and partnership with them…I think Measure 101 was maybe like a quarter-turn on that,” per the union representative. The hospital representative offered a similar assessment, noting how the experience of working together had been “illuminating to both sides” after having a fractious relationship in the past. The political representative remarked how future healthcare ballot-measure efforts may not “have been possible, or would’ve looked really different, had [Measure] 101 not happened.” They continued that “[we] wouldn’t have had the campaign relationships…[nor] identified the shared values around healthcare funding, around upstream prevention efforts.”

Many coalition members also spoke to a sense that Measure 101's passage had reaffirmed healthcare’s value proposition as a fundamental right in the state. The CCO representative, for example, said they believed its passage clearly “affirmed that idea.” In contrast, the union representative thought Measure 101 “clearly laid a statement in the ground and laid a line in the sand that Oregonians believe that every Oregonian should have healthcare.” The political representative, too, affirmed that “we really did try and center [the

campaign] in Oregon values." One of the campaign's most distributed television and online advertisements notably echoes this sentiment. It features a nurse who declares, "I want to live in a state where everybody can receive the healthcare that they need."

Issue framing. The chief element of Oregon advocates' political rhetoric was their framing of expansion-funding to protect the most vulnerable in society. According to the campaign operative I spoke to, 'kids' were central to this argument. Appeals to protecting children make up almost a fifth (17%) of total coded references and over half (52%) of all references related to protecting vulnerable groups. Two of the most common refrains employed emphasize the protection of 'vulnerable children, seniors, and people with disabilities,' and more broadly, of '1 in 4 Oregonians, including 400,000 children' (Overton, 2017; Yes for Healthcare, 2017). Most campaign television advertisements portrayed children in a family or medical context narrated by a healthcare provider or parent who spoke to the importance of Medicaid coverage for their children and family. Overall, vulnerable groups were ubiquitous throughout more traditional media (television ads, newspapers, and mail), more than three-quarters (77%) of which presented one or more vulnerable groups as needing protection.

Also heavily underscored were the '160+ trusted organizations'– businesses, nonprofits, advocacy groups, and healthcare providers – endorsing the measure. Groups like AARP of Oregon, the Oregon Medical Association, Oregon Nurses Association, and individual doctors and nurses were key spokespeople (or "validators," per the operative) for the campaign. One illustrious campaign tweet brazenly advised that, on matters of personal health, it is best to 'trust a physician, not a politician' (Yes for Healthcare, 2017). Newspaper

editorial boards, firefighters, educators, and civic organizations like the League of Women Voters were other institutional endorsers frequently mentioned in both social media posts and more traditional media. Almost two-fifths (38%) of conventional media analyzed featured endorsements by one or more of these groups. These also included several newspaper op-ed pieces by physicians supporting the measure. The overwhelming show of institutional and expert backing arguably offered Measure 101 advocates the starkest contrast with their opponents of all the cases analyzed.

Solidaristic, or community-oriented, appeals also composed a significant portion of campaign rhetoric relative to other themes and cases. Appeals to solidarity took the form of 'should/deserve' statements about healthcare access and affordability, as in 'no Oregonian should have to go without the care they need;' 'everyone should be able to see a doctor when they are sick;' 'we all deserve to be healthy;' and 'everyone deserves healthcare/the chance to be healthy' (Yes on Healthcare, 2017; APANO, 2017). Another common refrain infused this moral necessity with the structural-economic impediments associated with the exorbitant cost of health care and its consequences. Campaign rhetoric implored support for expansion-funding 'because Oregonians…deserve to get the healthcare they need without worrying about medical bills bankrupting them' or 'choos[ing] between buying food and going to the doctor' (Yes on Healthcare, 2017; Care Oregon, 2017). One social media post quoted a doctor as describing 'medical help in times of sickness and injury without fear of financial ruin' as a 'basic good which unites us all' (Care Oregon, 2017). These types of appeals were featured in almost half (46%) of traditional campaign media analyzed and a smaller (14%), though a nontrivial portion of online social media posts. For instance, newspaper op-ed

writers referred to healthcare provision as a ‘social responsibility’ involving the ‘care of’ or ‘prioritiz[ation]’ of neighbors (Burton, 2018; Woods, 2017; Wilde, 2018).

Even traditional health-related appeals cast the benefits of expansion-funding in terms of community health broadly, not just individual health. Statements supporting expansion-funding like ‘healthy, thriving families lead to strong, resilient communities,’ and expansion ‘will build stronger families, communities,’ attempt to link individual and communal health in this way (APANO, 2017; APANO, 2018). Others more explicitly framed the issue as ‘not only about the health of individuals but the health of our community’ and ‘keep[ing] us all healthier’ (Wilde, 2018). Moreover, the sheer magnitude of potential social repercussions in the event of a failed measure tended to raise the stakes for a large swath of the public. Advocates pointed to how the measure would ‘preserve healthcare for hundreds of thousands of Oregonians,’ while its failure could ‘compromise hundreds of thousands of Oregonians’ health’ (Yes on Healthcare, 2017; Woods, 2017). Based on actual program enrollment, these numbers magnify the threat or opportunity posed by the measure and perspective the extent of the collective impact. Although this kind of framing constitutes a smaller portion of overall health-related references, which overwhelmingly focus on preventative health and healthcare improvements more generally, it is clear that communitarian interests were not exclusive to strictly moral claims.

Economic and fiscal arguments for continued expansion invoke communal or shared costs borne by uncompensated care in hospitals and clinics. This argument underscores the importance of federal matching funds for ameliorating emergency room health care costs and is present in all cases. Here, advocates warn of increased shared costs in the wake of

expansion-funding rescission, arguing how ‘we all shoulder the burden of [the] uninsured’ (Baugher, 2018). Others said the measure’s failure would ‘drive costs up for all of us’ or ‘raise costs for everyone’ (Yes for Healthcare, 2017). Advocates spoke similarly to the corollary effects of successful passage as ‘stabilizing costs for all of us/everyone;’ ‘keep[ing] premiums lower for everyone;’ ‘sav[ing] everyone money;’ and ‘bring[ing] costs and premiums down for everyone’ (Yes for Healthcare, 2017).

Moreover, advocates stressed how federal matching-funds meant ‘pay[ing] for healthcare for our kids’ (Care Oregon, 2017). A direct social determinants logic asserts that ‘for communities to thrive economically, families need access to healthcare’ (Taylor et al., 2018). However, it is unclear whether these cost appeals pertain to Medicaid expansion per se or reinsurance provisions included in the omnibus funding package and subsequent ballot-measure. Regardless, the rhetoric of costs remains the same: embedded within a language of social ties, in which costs and benefits of communal well-being redound to every member of society.

Utah’s Proposition 3: Challenging “bootstraps” culture. Advocates in Utah, like Maine, were seeking a full expansion of their state’s Medicaid program under the ACA after years of legislative obstruction by Republican state leaders. Therefore, much of the rhetoric tends to play up the benefits of reform, especially to the state’s economy. But campaign rhetoric also sought to dispel a predominant cultural belief linking social services' deservingness with work by acknowledging poverty's structural realities. At the same time, however, advocates cast expansion coverage to promote individual self-reliance among beneficiaries. The result is political rhetoric marrying a structural critique of prevailing

notions of deservingness with a functional view of social policy as primarily labor market-enhancing. State political realities would also play a decisive role in campaign-support dynamics among potential health care allies, a key source of issue credibility.

Opponents of the ballot measure zeroed-in on the the perceived negative economic and social aspects of reform. They argued expanding Medicaid "incentivized more spending on able-bodied adults than on the vulnerable" (Utah Voter's Pamphlet, 2018). Expansion was described as a "budget-buster," forcing taxpayers "to pay [an] ever growing bill," and arguing against raising the state's sales tax to finance it. Opponents preferred "Obamacare expansion" over Medicaid expansion in an effort to link the policy to the controversial federal legislation. The Governor and almost the entire legislature were against the measure.

Coalition dynamics. Counter-political headwinds hampered advocates' ability to garner robust support for expansion within the state's healthcare community. A Republican-dominated political context was a significant factor influencing potential allies' decisions to endorse the pro-expansion effort. One advocate noted how they "never had much support from our medical associations or our hospital associations;" instead, this mostly came from "individual practitioner groups." While another explained how "providers" and "hospitals and hospital associations" were reluctant "to throw any money [behind the issue] because they were scared of the legislative response and didn't support us because the legislature was so opposed." The state's most prominent hospitals and providers, some of whom are largely publicly funded, were "really wary of angering the legislature because they don't want to get their funding cut." However, advocates pointed to a "long list of nurses and doctors who publicly endorsed us" that could offset this lack of traditional institutional support.

According to one advocate, the Church of Jesus Christ of Latter-Day Saints (LDS) withheld vital support, which was "problematic" because of the church's tremendous political clout in state politics. "If you get their [LDS] blessing, you're good; if you don't, then it's an uphill battle," the advocate noted. But, they added, even as these more prominent institutional players never supported expansion outright, they also never "spoke against" it either, deciding to remain "neutral." Nevertheless, their refusal to officially endorse or put resources behind the effort initially put the campaign at a disadvantage in a hostile political environment disinclined to expanding government social supports. An active, coordinated effort in tandem with the state's Democratic Party was also absent for strategic reasons, as one operative admitted having distanced themselves politically from the party "because we needed to look as extremely nonpartisan as possible." They also added that "in terms of the big institutions, we kind of ran into a lot of brick walls where people were privately very supportive, but publicly wouldn't stick their necks out." Thus advocates had to build a public campaign capable of circumventing these institutional partisan antagonisms, something they believed could be achieved by foregrounding the economic arguments in favor of reform.

Arguably the decisive source of support, financially and technically, came from the Fairness Project, an advocacy organization formed in 2015 with the explicit aim of leveraging state initiative and referendum processes to advance a progressive policy agenda. A campaign operative recounts how their earlier legislative efforts had "caught the eye" of the group, who then "started approaching…advocates on the ground about their willingness and interest in doing a ballot measure." Local political barriers and an unexpected slew of liberal ballot measures starved the campaign for resources. As a result, the Fairness Project

"funded 99 percent of the campaign" and provided the critical technical heft needed to wage a statewide effort, according to the operative.

Issue framing. At the center of advocates' persuasive effort was the state's economy. One campaign operative summed up the strategy as "lead[ing] with the purse strings and clos[ing] with the heartstrings." The first component relied on empirical estimates of reform's positive economic impacts on job growth and overall state stimulus. In contrast, the second part concerned personal Medicaid success stories of those who fell on hard times and for whom the program subsequently aided. Personal stories also confound expectations about the relationship between social programs and poverty by highlighting Medicaid's less-popularized, social mobility aspects. Moreover, they showcase the realities of low-wage employment, lack of benefits, and far-off state policy decisions that structure someone's opportunities for health care and financial stability. However, its rhetorical core is a culturally aligned concern for self-reliance and the enhancement of individual capacities that serve broader social efficiency goals of a healthier workforce and more resilient families.

Fastening disparate appeals together is a common language of investment. For instance, advocates cast Medicaid expansion as a 'sound investment in the future of our state, both economically and medically' (Wright, 2018). Campaign literature frequently touts studies about the return on investment of federal Medicaid matching funds, claiming how 'Utah gets back $9 for every dollar we spend' (Utah Decides Healthcare, 2018). The notion of investment seeps into a discussion of the lives of those who Medicaid expansion would most impact as well. Medicaid expansion was portrayed as 'an investment in people' and as a policy that 'will allow Utahns to invest in themselves and their families' (Jones, 2018).

Deeply implicated in this investment model of social policy, where Medicaid functions primarily as a program 'used to help people get ahead,' is a social interest in optimizing labor market efficiencies through a 'healthier workforce' (Jones, 2018; Shepherd, 2018).

One advocate's assertion that 'a healthy economy needs healthy people' succinctly captures this idea of social policy as an economic handmaiden (Shepherd, 2018). Much rhetoric about health – accounting for roughly 11% of total coded content – emphasized how reform would 'improve health outcomes;' 'save around 240 lives annually;' 'provide needed healthcare to 150,000 Utahns;' and generally, 'make a healthier Utah' (Ward, 2018; Beshear, 2018; Utah Health Policy Project, 2018; Utah Decides Healthcare, 2018; Deseret News, 2018). But mixed in with this health-based messaging focused on the economy, explicitly buttressing labor market efficiencies. The expansion could help people 'lead healthier, [and] more productive lives' (Gehrke, 2018).

The argument boils down to a conventional understanding of the relationship between one's health and productivity, whereby '[h]ealthy residents are better able to work and contribute to society' (Biskupski, 2018). Coverage expansion furthers this goal by providing 'a better ability to be employed;' 'keep[ing] adults working to support their families;' ensuring people 'get healthy and get back to work;' and overall, by 'keep[ing] more Utahns working and contributing to the growth of our great state' (Utah Decides Healthcare, 2018; Christiansen et al., 2018; Shepherd, 2018). Taken together, this meant 'less work delinquency, and more consistent local business services for everyone,' connoting health coverage expansion with an expansion of the state's productive capacities (Jones, 2018).

Alongside their case for social policy as effective economic policy, advocates also leveled a critique against prevailing notions of relative deservingness of social benefits among different recipients. Central to this appeal was a rhetoric of work portraying beneficiaries of expansion as 'hardworking' or holding 'values of hard work' (Utah Decides Healthcare, 2018; Jones, 2018; Shepherd, 2018; Rathi, 2018). This manifested most often as descriptors of likely beneficiaries. But advocates also reframed expansion away from its creating 'incentives for people to avoid working,' and instead towards the idea of its 'reward[ing] hard work' (Jones, 2018; Martinez, 2018). Advocates did this by elevating individual stories of those personally impacted by Medicaid, whose experiences tended to contradict a widely-held political belief in social welfare dependency and illuminated the structural disadvantages of low-wage work. Thus, a relatively overt structuralist critique emerges to penetrate and confound widespread individualistic explanations for existing social conditions.

Recipient advocates expressly identified the need to challenge a political culture that viewed 'poverty [as] a choice' (Martinez, 2018). As a result, they drew attention to the randomness and universality of healthcare need, stating how an 'accident could happen to anyone,' or how 'you never know what's in store for you,' in terms of your health (Sweeney, 2018). Moreover, advocates characterized Medicaid as 'help[ing] Utahns onto the path of self-reliance as they pull themselves out of poverty' (Martinez, 2018). One recipient claimed Medicaid coverage had done just that by 'allow[ing] me to pull myself back up…through recovery and hard work' (Sweeney, 2018). 'There's this culture of bootstraps and making a better life for yourself,' another former recipient remarked, 'but we don't let people do

that' (McKitrick, 2018). Social barriers to program access, like the 'stigma around social programs,' illustrated the importance to one recipient of changing the perceptions of Medicaid as 'a taboo subject,' thereby making it more likely for people to live up to an oft-revered 'notion of self-sufficiency' (Martinez, 2018). Stories of recovery from drug addiction or health tragedies reveal Medicaid's socially mobile function in society. Advocates interwove these personal stories with a broader structural case for expansion by illuminating the different policy and systemic barriers shaping health coverage opportunities for low-wage workers in a state.

Structural arguments made an institutional case for expansion based on a perceived lack of health coverage opportunities within the US's peculiar employer-based insurance and federal social welfare systems. The point is twofold, managing to lodge critiques at both state lawmakers in Utah for failing to expand coverage under the ACA and a predominantly employer-based health insurance system that fails to cover every worker or keep costs low enough to make individual coverage affordable. Their rhetorical combination informed advocates' framing of the problem around the 'coverage gap,' a technical term for the widespread lack of affordable health insurance resulting from an eligibility gap for different federal health benefits caused by a state's failure to expand Medicaid. In other words, those 'who make too little to afford healthcare on their own, but too much to qualify for Medicaid' (Utah Decides Healthcare, 2018). The coverage gap was central to this structural argument.

Advocates ascribed the coverage gap's causes to state health policy and the relative unavailability of coverage in low-wage occupations – dually structuring health coverage

opportunities – as opposed to an individual's willingness to work. 'Working-class people,' one op-ed explained, lack health coverage 'not because they didn't have jobs but because their employers didn't offer it, or it was too expensive to buy' (Beshear, 2018). Others noted how many 'work at least one, and many two, or more jobs,' and that sometimes a person's 'mental, emotional, physical, and familial challenges' prevent their accessing employment that offers quality health coverage (Armstrong, 2018; James, 2018). Advocates framed barriers to coverage as institutional and social, rather than purely individual, in nature.

Moreover, because the state legislature had only implemented partial-expansion (up to 100% FPL), advocates brought attention to the work disincentives of such a half-measure. Advocates cast Prop 3 as a solution to a traditionally neoliberal concern: 'Utahns at low-wage jobs who get a promotion or take on more hours, shouldn't have their healthcare taken away. Prop 3 fixes that' (Gehrke, 2018). Advocates reframed the traditional rhetoric of work disincentives in social policy – which emphasizes its dampening effects on labor market participation – toward a view of expanded eligibility which encourages work through consistency of social benefit access, in which health security sustains – even facilitates further – employment opportunity. Moreover, advocates stressed that Medicaid policy should 'not take away from,' or 'punish,' someone 'who works extra hours,' but instead 'reward hard work' (Utah Decides Healthcare, 2018; Martinez, 2018). These issues fed a perception of ineffectual and inadequate healthcare policy that advocates would lay at the state's legislative leadership feet.

State policymakers received criticism for their role in limiting health coverage in the state. Advocates made a general argument about the differences in state-level policy and the

chance impact of one's state residency in determining their relative healthcare opportunity. For example, advocates argued that, for sick, low-income individuals, 'your healthcare options might be really different' depending on whether your state expanded Medicaid or not (Utah Decides Healthcare, 2018). Advocates reminded voters of the source of the coverage problem in the state's failure to expand fully. '[T]his decision [by the state legislature] created a coverage gap for hardworking Utahns' (Rathi, 2018). They further drew out the implications of this when explaining how '[e]xpanded Medicaid could have helped many, but they did not qualify with restrictive eligibility requirements and limited coverage caps' (Hesligton, 2018). Advocates brought attention to a seemingly arbitrary healthcare situation that policymakers could have remedied had they chosen a different course. Thus by reorienting coverage issues around policy decisions instead of people's individual choices, Utah advocates made a structural case for expansion that went further than those made by other state-level advocates.

Maine's Question 2: The positive-sum society. Maine advocates blazed the trail for subsequent statewide expansion campaigns in other states. Their rhetorical strategy, as such, ran the gamut in terms of the kinds of appeals employed. In all, the strategy predominately leaned on a traditional appeal to the economic and health benefits of Medicaid expansion for the state and local communities. As in Utah, the economy was front and center of their case for expansion and closely tied to healthcare outcomes, indicated by the claim that Question 2 would 'help the economy and save lives' (Mainers for Healthcare, 2018; NASW-Maine, 2018). However, advocates' solidaristic language most closely mirrored that of Oregon's advocates in terms of its moralistic construction. Thus, Maine's expansion effort melds the

other two state cases' traits, joining a predominantly utilitarian argument for expansion with solidaristic appeals. Political dynamics of a skittish healthcare community and a hostile state government in the governor were similar institutional barriers faced by Utah advocates. Maine seemingly falls in between the other two cases' experiences, fitting more practical appeals with a relatively independent political culture.

Opposition to Question 2 was led by the "Welfare to Work" committee, and included Republican members of the legislature, the governor, and the NFIB of Maine. The group argued that Medicaid expansion would "saddle Maine taxpayers with even more welfare costs" and lead to a "bloated Medicaid system" that crowds out funding for the truly needy (Cousins, 2017; Maine DHHS, 2017). Opponents used the pre-fix "welfare" when referring to Medicaid expansion and questioned the idea of providing health benefits for "people able to work" and with no "skin-in-the-game" (Sirocki, 2017).

Coalition dynamics. The effort to expand Medicaid in Maine began in the state's legislature several years before Question 2. Maine's People's Alliance (MPA) spearheaded a coalition of progressive activists and medical groups to push lawmakers and the governor to pass full ACA expansion. But some medical groups, allied initially with expansion advocates in these early legislative efforts, had initially bowed out of the referendum campaign. "When we transitioned to try to take it to the ballot, that's a much riskier undertaking for a lot of those types of organizations," a campaign operative said. They also noted how "some of them did, in the end, end up endorsing" but were not officially involved in the public campaign. Moreover, the state's hospital association was "not with us in the way we had hoped they would be," but they also "didn't come out against us." The most significant factor

shaping these organizational stances was the Republican governor, who opposed expansion outright.

Political factors involved in campaign coalition dynamics interacted similarly to other cases, mediated by an incompatible political context. According to the operative, the hospital association was "a little nervous about getting on [the governor's] bad side or doing anything that would mean funding for them," according to the operative. This turned out not to be the case for independent hospitals, though. "But towards the end of the referendum campaign," they noted, "some of the hospitals were on board in a significant way." So an initial reticence on the part of hospitals to support the expansion campaign based on political realities would turn into support towards the end of the campaign.

On the other hand, individual healthcare practitioners showed support from the outset, as many nurses and doctors participated in campaign ads and mailers. Nurses, especially, were desirable as campaign surrogates because "everyone trusts the nurses," per the operative. The campaign also leveraged Democratic Party support more than in Utah; however, this turned out to be less coordinated and inclusive than in Oregon's case. "Some of their core volunteers…did work on their local committees. But there wasn't any official connection," according to the operative.

Issue framing. Advocates' primary economic appeal centered around a fiscal stimulus logic based on the injection of federal matching funds into the state's economy. Like in Utah, the byline for this argument characterized expansion as 'a sound business decision,' and a policy decision that 'would have enormous benefits for Maine's economy,' giving the state a 'much-needed shot in the arm' (Saviello, 2017; Dingman, 2017; Press Herald, 2017). For

instance, advocates referred to an ‘economic stimulus’ from the expansion that would be greater for rural areas and provide the state a ‘steady payment source through economic slumps’ (Kilbreth, 2017). A pro-work argument was also advanced, emphasizing expansion’s effects on ‘improved work readiness’ and ‘ability to find and retain work,’ especially for those with pre-existing conditions (Lewis, 2017; Kilbreth, 2017). Advocates frequently used other expansion state experiences as examples of where ‘investments in healthcare [had] created new jobs and spurred economic growth’ (Bangor Daily News, 2017). A similar positive-sum narrative is advanced for health-related appeals, which Maine advocates employed at a higher rate than other cases (see Table 6).

In addition to the economic benefits, advocates focused on health benefits to individuals regarding care needs, disease prevention, and enhanced mortality. The expansion was cast as a way to ‘improve [the] health of Maine’s people’ and to ‘save lives’ (Kilbreth, 2017; Mainers for Healthcare, 2017; Maine Children Alliance, 2017; NASW-Maine, 2017). As one op-ed put it, ‘More people will get care that keeps them healthier and saves lives' (Fried, 2017). Moreover, they argued expansion would let people ‘access life-saving health care,’ or ‘provide life-saving healthcare to thousands of working Mainers’ (Rothe, 2017; Graham, 2017). The campaign featured personal stories of Medicaid recipients here as well. One spoke to how ‘Medicaid saved my life and my family,’ while another bluntly claimed that ‘without Medicaid, I would be dead’ (Pineo, 2017). Advocates also stressed the specific health care gains to newly eligible people in ‘access to primary care, preventative medicine, [and] basic health services that are essential for a healthy life’ (Peterson, 2017). Advocates addressed the interrelatedness of health and economic benefits, though not as

extensively as in Utah, where advocates made a more explicit link of expansion to overall economic productivity.

Advocates instead focused on the impact on local communities and the overall state budgetary picture. Expansion, advocates claimed, would ‘stabilize our community hospitals and local health systems’ and ‘help hospitals to continue to serve their communities’ (Churchill, 2017; Graham, 2017). Advocates portrayed 'struggling rural hospitals’ in need of vital assistance to remain operating and serving the state’s rural communities, asserting that ‘rural hospitals need Medicaid expansion’ (Caron, 2017; Saviello, 2017). Rebutting opponents’ criticisms of expansion as too costly, advocates claimed instead that increased coverage would ‘likely produce budget savings’ from increased preventative care access (Mainers for Healthcare, 2017). ‘When people can see a doctor more regularly, their health often improves, and their medical care is less expensive in the long term,’ one op-ed explained (Bangor Daily News, 2017). Thus, expansion simultaneously represented a solution to a vulnerable healthcare system and a sluggish state economy.

As in Utah, Maine advocates stressed the ‘coverage gap’ concept and an appeal to vulnerable populations, both though to a lesser degree comparatively. A similar critique of the health care system and its inequitable distribution of coverage benefits referenced ‘the cracks of society’s disjointed supports’ (Lewis, 2017). Advocates noted that most beneficiaries are ‘working, but don’t get coverage from their employer,’ and ‘can’t afford the cost of individual insurance policies’ (Graham, 2017; Kilbreth, 2017). In a retort to opponents’ efforts to portray Medicaid as ‘welfare,’ advocates sought to confront this familiar

framing with one of their own by simply declaring ‘Medicaid is insurance’ (Bangor Daily News, 2017).

Additionally, appeals to the most vulnerable social groups referenced ‘poor and struggling Mainers;’ ‘working moms, veterans, people struggling with medical conditions;’ and ‘low-income Mainers struggling with opioid addiction,’ a public health crisis that has disproportionately afflicted the state’s communities (Pineo, 2017; Phelps, 2017; Graham, 2017). However, advocates did not consistently promote a single group as a deserving beneficiary over others except single mothers or ‘mothers and hard-working families’ (Graham, 2017). A campaign operative confirmed this framing stating, “we ended up elevating single moms…[who were] working jobs and trying really hard to keep their families afloat and still couldn’t afford health insurance.” Advocates promoted stories and images of single mothers and their children on traditional television advertisements and social media. But unlike in Utah and Oregon, kids were not a distinctive focus of the overall appeal to vulnerable groups.

DISCUSSION

Medicaid coverage expansion produced general electoral effects and additional partisan effects depending on the relative "partisan match" of electorates and parties. An uptick in support for Democrats – strictly contingent on a favorable partisan electorate – only partially confirms the basic policy feedback thesis of political returns from beneficial social policy, as coverage gains are likely merely indirectly consequential for Democratic political fortunes. This outcome corresponds with those of others who found no significant electoral impacts from Medicaid expansion for Democrats at the presidential level (Hollingsworth et al., 2019). However, this study does reveal evidence of specific positive coverage-level effects under certain partisan political conditions.

Greater Democratic support in such favorable circumstances may in part be due to an enhanced sense of political efficacy and participation among new beneficiaries. Given the observed positive impacts of expansion on voter participation, the relationship of enhanced vote shares to more Democratic and Republican partisan electorates becomes clearer. Mettler's (2018) finding that "usage of visible means-tested social policies generates a greater appreciation of government," does not seem to translate into greater Democratic support, even as the proverbially "pro-government" political party (p. 105). Given partisanship's strong, though not immutable, influence on political behavior, it is the most likely reason for the lack of an observed direct feedback link of coverage gains and Democratic electoral support more broadly.

By contrast, the observed penalties for Republicans – beyond a one-to-one trade-off of support with the other party – suggests a wholly different dynamic. A larger voting

electorate (Clinton and Sances, 2018; Baicker and Finkelstein, 2018) and drop-offs in voting by disillusioned partisans from a backlash to expansion (Haselswerdt, 2017) could explain the losses. Whatever the cause, though, Republicans are generally significantly electorally disadvantaged by expanded Medicaid coverage. Resistance to expansion most likely reflects both an ideological antipathy and a political calculus based on denying (indirect) electoral advantages to Democrats while heeding the policy preferences of rank-and-file party members who remain narrowly opposed to expansion (Commonwealth Fund, 2020). Given the highly polarized nature of expansion politics, Republican state lawmakers lack a clear political incentive for accepting federal expansion. This study's findings confirm those of others who found Republican efforts to undermine the ACA (e.g., refusing to implement many of its key programs) paid real electoral dividends (Kogan & Wood, 2019). As a result, pro-expansion advocates are increasingly choosing to circumvent Republican legislatures with direct appeals to non-expansion state publics, where broad majorities overall (e.g., 73% in Florida and 67% in Texas) approve of expansion (Commonwealth Fund, 2020).

Where advocates' policy aims were out-of-step with the predominant political culture (e.g., Utah), they experienced difficulty assembling broad-based coalitions of support. Where they were more aligned (e.g., Oregon), advocates built extensive networks of support spanning the medical industry, civic groups, and voting constituencies. Maine's case evinces somewhat of a middle-ground where advocates faced institutional barriers in the Governor and leery hospital groups while garnering broader support from the legislature and broader public.

Advocacy framing reflected a state's unique politics, predominately eschewing abstract rights-based arguments for more practical appeals to improving state economies and community-wide health. This more individualistic tact is perhaps more accurate of advocates in Maine than Utah, where expansion was arguably framed as a fundamental demand for the state to better meet the public's basic health and economic needs. Utah, however, arguably exhibited elements of both individualistic and traditionalistic polities. While emphasizing improvements to the state economy and well-being, the necessity advocates felt to forcefully counter anti-welfare attitudes signals a traditionalist cultural milieu perhaps less animated by public welfare concerns. Only in Oregon did communalist rhetoric pervade economic- and health-based appeals while elevating vulnerable groups perceived to be most at risk by expansion's rescission. In that sense, Oregon typifies a far more moralistic political culture than the others. Their varied experiences point to how the early politics of late program adoption can shift with time and as social interests proliferate. However, exceptions do exist (as the 2018 failure of an expansion-financing measure in Montana illustrates).

In Oregon, the threat posed by Measure 101's potential failure engendered a virtual political immune response from a broad coalition of affected industry and civic groups. The coalition's sheer size and broad representation of varying constituencies presented overwhelming force, which arguably signaled the stakes of the issue to voters. This is evident in the eventual electoral returns where solid majorities in several Trump-voting "pivot" counties approved the measure (Ballotpedia, 2018). However, out of this experience came a further consolidation of relationships and commitments on new and existing groups within the Medicaid policy community. These included incorporating new interests (i.e., CCOs) into

program-funding mechanisms and innovations in cooperation between historically opposed social interests (i.e., unions and hospitals) and the symbolic reaffirmation of state political values perceived in Measure 101's success.

The foregrounding of traditionally deserving groups – primarily children – in Oregon also proved a powerful rhetorical and institutional safeguard for protecting all beneficiaries within the Medicaid expansion program. Using the image of highly-deserving beneficiaries in defense of newly ACA-designated adult beneficiaries obscures the latter and makes impractical any distinction in their relative program prerogatives. This kind of institutional protection – through "banding together" – was once a key feature of midcentury New Deal welfarism before a 'workfare' turn in federal social policy began breaking apart public assistance programs into separate program constituencies (Bertram, 2015). However, Skocpol (1995) spoke to the purported limits of "progressive children's advocacy" as a political strategy at a time when it was not uncommon for the public to view kids' programs as "a cover for a welfare program" (p. 310). In this case, advocates leveraged a level of social approval for children's programs to secure the gains of another whose relative deservingness and institutional clout are perhaps less established in the public eye.

Although it was commonplace for states to retrench program benefits for adult beneficiaries before the ACA, these earlier state-level expansions were often experimental, limited in form and duration, and subject to shifting fiscal and political conditions (Olsen, 2010; Thompson, 2012). This changed with the ACA's infusion of federal financial support into state expansion programs, which solidified adult beneficiaries' status as a near-permanent constituency, albeit only in expanding states. Nevertheless, elevating particular

beneficiaries whose social claims are already secure vis-à-vis the public and political classes (e.g., children) could belie real insecurity in the politics of deservingness for new adult beneficiaries under expansion, made all the more apparent by the post-ACA resurgence of conservative welfare discourses and reforms (Grogan et al., 2017).

On the other hand, the promotion of lives improved by Medicaid access – low-income, single mothers, and those battling addiction – in Utah and Maine seemed to challenge prevailing stigmas associated with these groups. Their promotion might signal evolving public perceptions or simply a willingness by advocates to force public reassessments of widespread social definitions of deservingness. Once a common trope of the early 1980s and '90s anti-welfare rhetoric (Bertram, 2015), single mothers' prominence now, especially in the context of expanding social welfare benefits, seems a remarkable development. Advocates sought to undermine longstanding individualist notions of welfare deservingness by promoting historically stigmatized groups within welfare discourse and connecting social need explicitly with prevailing political and economic structures (e.g., explaining the "coverage gap" and the U.S.'s peculiar employment-based insurance system).

Moreover, advocacy rhetoric in Utah, and to a somewhat lesser extent in Maine, advanced a neoliberal conception of Medicaid as augmenting state economic capacities by raising individual productive potential. Representations of beneficiaries as 'hard-working' attempt to increase their perceived 'moral capital,' whereby work ethics become "infused with moral value…to define who is and who is not an upstanding member of the community" and thus deserving of social security (Sherman, 2009). The focus on productivity and efficiency attempts to redefine Medicaid's policy rationale away from a passive safety net and towards a

proactive social program conception of furthering individual self-reliance and labor market functionality. Health and economy are socially determined, interdependent aspects of society, where the gains from effective management and improvement of one more or less redound to the other. This new (or perhaps less familiar) understanding of Medicaid as being socially valuable for its productive ends contrasts starkly with conventional welfare-dependency narratives of recent decades.

As has been noted already, once established, positive policy feedbacks can create the conditions that make social policies challenging to dislodge. But feedback of political support for the party responsible is likely quite limited (if nonexistent), even as this study shows a slight electoral boost for Democrats from favorable partisans for expanding Medicaid coverage. Partisan loyalties may undermine a pure translation of voter appreciation into political rewards at both the individual and institutional levels. These limits are no more apparent than in the failure of Montana's I-185 (an expansion-financing measure similar to Oregon's) in 2018 where, without oversimplifying, 'working-class' and 'welfare' politics collided under a proposed cigarette tax hike resulting in the rejection of continued financing for Medicaid expansion.

Others have noted the misplaced faith in policy feedback's promise of generating stable political coalitions, calling instead for a greater focus on "grass-roots" party organization-building as an alternative (Galvin & Thurston, 2017). Though not explicitly party-electoral efforts, the ballot measure campaigns indicate a potential for building upon social programs through civic action. Skocpol (1995) identified this kind of politics as a "broader and democratically rooted approach to issues of…security" at a time when

"Americans want to feel they can do something themselves, in partnership with government" (p. 310). Moreover, although greater access to social benefits makes intuitive sense as a remedy for decades of conservative appeals "to an American public skeptical that the federal government can do anything well," access alone may be insufficient to the task (Skocpol, 1995, p. 307). Thus, where institutional barriers have stymied feedback, pro-expansion organizing efforts have stepped in to push program developments forward. And even in electoral defeat, program feedbacks (e.g., fear of political fallout, newfound commitment to provisioning benefits) nevertheless force state leaders to make policy decisions regarding the form and function of Medicaid in their states.

For example, the failure of Montana's Initiative 185 nevertheless prompted state Republican leaders to seek a legislative fix that would leave the expansion program intact, albeit in a more conservative form (Hanson, 2019). Utah's Republican-dominated legislature similarly moved to put a conservative stamp on its Medicaid expansion program following Proposition 3's public approval (Goldstein, 2019). In both cases, conservative policymakers decided to keep their expansion programs, if not in form, then in fact, and only after public advocates secured the public's full democratic blessing. But the divergence in form and substance of state Medicaid regimes should not obscure the general expansionary direction of these reforms – regardless of their ideological configurations – unleashed by national health reform a decade earlier.

Policy Implications and Future Research

An estimated 4 million low-income Americans currently residing in the 12 remaining non-expansion states, who would otherwise be Medicaid eligible had these states expanded

their programs, lack access to health benefits under the ACA (Garfield & Orgera, 2021). The Fairness Project, the national progressive organization behind successful expansion campaigns in Oklahoma and Missouri, has recently indicated it is training its sights on Florida as the next Medicaid expansion battleground. Success there would mean expanded coverage to nearly 800,000 eligible people, only second to Texas in terms of social impact (Kliff, 2020). However, these potentially outsize gains are likely to come at increasing cost and effort compared to previous expansion campaigns as the context shifts to a Southern partisan-political and cultural terrain. The opposition of political elites and institutions to popular social and economic policies to maintain rigid social hierarchies is well known (Myrdal, 1962; Quadagno, 1994; Katznelson, 2005, 2013). The residual pull of historical legacies in contemporary Southern politics presents a truly archetypal traditionalistic polity for which advocates will contend.

Future expansion advocacy should consider foregrounding practical, context-specific economic and health appeals while identifying those unique values-based concerns which are most salient to a state's electorate. Institutional and political context matters. Conventional arguments inveighing against the scourges of welfare and taxes should be preempted and met directly with rhetoric of social costs and gains compared to the status quo, alongside an elevation of community members, medical experts, and those most vulnerable to health crises. As no one-size-fits-all approach exists for expansion advocacy, much will depend on activists' local knowledge and a capacity for leveraging the credibility of community institutions as trusted messengers in the debate. The degree to which advocacy bypasses or

otherwise resists setting the terms of debate on partisan grounds, the greater will be its formidability to opposition arguments.

Though Oregon's rhetoric and coalitional response to Medicaid expansion were consistent with that of a “moralistic” state polity, Maine and Utah seemed to exhibit qualities of both individualistic and traditionalistic state polities. However, policy advocacy in Maine seemed to turn on a model of political responsiveness to practical public concerns (i.e., more individualistic). In contrast, Utah advocates had to more forcefully preempt anti-welfare and social-structural considerations (i.e., more traditionalistic). The experiences of other states expanding (or failing to finance) Medicaid via ballot initiative – Nebraska, Idaho, Missouri, Oklahoma, and Montana – could reveal similar or more novel rhetorical strategies and the obstacles and advantages advocates face in different settings. A political-cultural lens is an appropriate starting point for future investigations of how advocates in these states built public support for expansion. Their insights would go beyond Medicaid advocacy alone and perhaps serve as a roadmap for social welfare advocacy more broadly.

The rhetoric, or ideas, used to justify social policy reform and the coalition of interests involved in managing and protecting them both play a role in shaping the politics and thus the institutions underlying expansion programs. However, it is crucial to recognize the limitations of rhetoric as sufficient for policy change alone. The policy-making context (i.e., the rules of the game) may significantly enhance or diminish the effectiveness of a specific rhetorical strategy (Karch & Rosenthal, 2017). As pro-expansion advocacy efforts emerge in the remaining holdout states, the issues animating social politics will inevitably drift towards more fundamental questions of deservingness, the role of government, and a

state's political values. They will be focusing on events that clarify and perhaps offer a chance to renegotiate the assumptions of existing social contracts. Advocates in Oregon, Utah, Maine, and elsewhere have created a roadmap for successful pro-expansion advocacy. Electoral incentives and advocacy strategies will continue to be decisive for those seeking to disrupt social politics in the years to come.

CONCLUSION

This study addressed the political implications of Medicaid expansion in their broad, electoral and specific, interpretative forms. Medicaid coverage expansions were not associated with significant electoral gains for Democrats broadly, but rather hinged on the relative Democratic-lean of state electorates. Republicans, on the other hand, are more likely to be electorally handicapped by increased Medicaid coverage generally at nearly all levels of partisanship. Partisan-political context similarly shapes the rhetorical framing and coalition-building opportunities of pro-expansion advocates. Pro-expansion advocacy tended to assimilate broader political-cultural ideas while also challenging welfare ideologies around deservingness and social policy efficacy. Moreover, where growing social interest in expansion converges with a favorable political climate, the resultant strengthening of prior political commitments is likely to further policy consolidation and resiliency to future retrenchment events in states which have enthusiastically embraced reform.

Expanding social policies remains a popular enterprise for advancing a broad-based social politics, notwithstanding the social and political forces impinging on its effects. Feedback from beneficial social policy – even under adverse partisan and institutional conditions – presents opportunities and challenges. The steady rise of one-party state governance over the last decade (Ballotpedia, 2021) will likely lead to greater divergences in state-level social policymaking, intensifying the disproportionate impact of place on citizens' welfare and political experiences (Michenor, 2018). The Medicaid expansion debate shows the necessity for advocacy to sidestep partisan politics for direct engagement with the public in a bid to win social protections for rising levels of social need.

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APPENDIX

Campaign Interview Guide

Introduction: I am going to begin by asking you some questions about your personal background and your experiences in Medicaid program advocacy

What position did you hold and with what organization in the [ballot measure] campaign?

(Begin Audio-recording**)**

Advocacy

Can you help me better understand how [ballot measure] came about and what your group's stance was on it?

About how many and what kinds of groups made up the [ballot measure] campaign? Was there a core group of organizations spearheading the effort? How was the coalition structured?

Did your campaign work closely with any political parties? If so, in what capacity? In general, what was your relationship to political parties?

What were some of the challenges faced by the campaign organizationally, politically or otherwise?

Can you tell me a little bit about how your campaign communicated the issue of Medicaid expansion to the public?

What aspects of the Medicaid program did you seek to emphasize most strongly with the public?

Measure 101 Coalition Interview Guide

Introduction: I am going to begin by asking you some questions about your personal background and your experiences in Medicaid program advocacy

What position did you hold and with what organization in the Measure 101 campaign?

(Begin Audio-recording**)**

Coalition Advocacy

Can you tell me about [organization]'s involvement in the effort to expand Medicaid in Oregon, historically, and with Measure 101, specifically?

What concerns or opportunities did Measure 101 present for [organization]?

What did continuing the Medicaid expansion program mean for [organization]?

How did [organization] support the campaign? What was their major role?

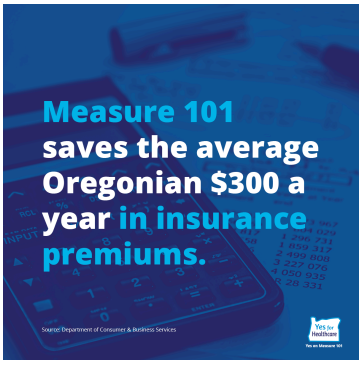
What was [organization]'s relationship with other coalition partners?

Did the campaign affect these relationships? How so?

Exhibit A. Oregon's "Yes for Healthcare" Campaign Images

Yes for Healthcare

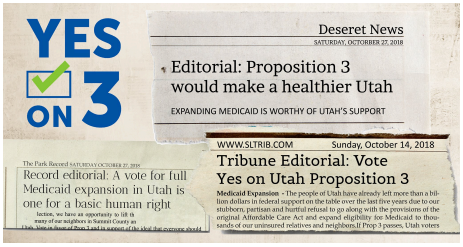
Yes on Measure 101

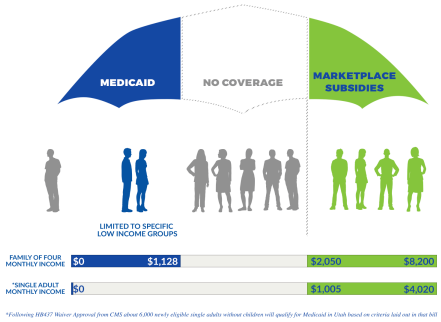


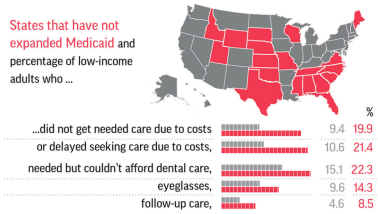
"As physicians, we see daily the power of giving all Oregonians access to health care. **Medical help in times of sickness and injury, without fear of financial ruin, is a basic good which unites us all.** (Passing Measure 101) will keep the doors of health care open to children, families and our elders when they need it most."

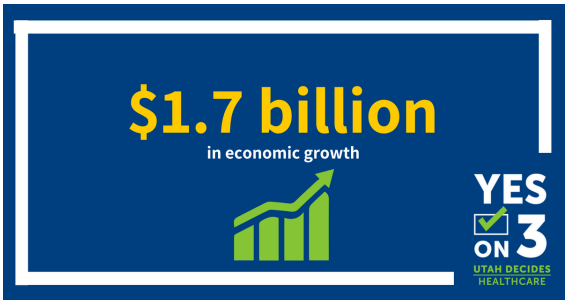
– Glenn S. Rodriguez, MD,
OMA trustee and MSMP past president

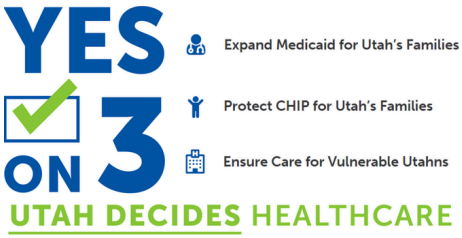
Exhibit B. Utah's "Utah Decides Healthcare" Campaign Images

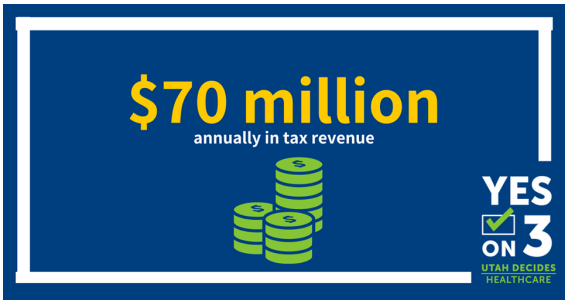


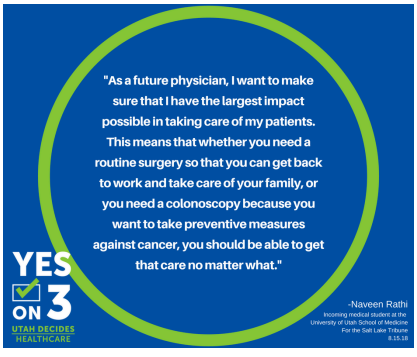












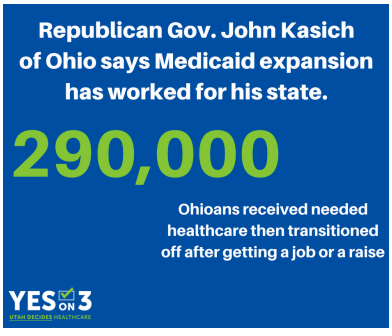


Exhibit C. Maine's "Mainers for Healthcare" Campaign Images