POLICY AND POLITICS: A CASE STUDY ON THE RHETORIC OF REPUBLICAN GOVERNORS ON THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION

by

Ariel M. Arguelles

APPROVED BY SUPERVISORY COMMITTEE:

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Dr. Richard Scotch, Co-Chair

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Dr. Meghna Sabharwal, Co-Chair

_____

Dr. Bobby Alexander

_____

Dr. Euel Elliott

To my family.

Always and forever.

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by

ARIEL M. ARGUELLES, BS, BS, MS

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Ariel M. Arguelles, PhD
The University of Texas at Dallas, 2019

Supervising Professor: Dr. Richard Scotch, Co-Chair
Dr. Meghna Sabharwal, Co-Chair

The passage of the Affordable Care Act (ACA) is arguably one of the most significant pieces of health care legislation passed in the United States in the past half-century, with the expansion of Medicaid eligibility dramatically altering the way Medicaid is delivered. Despite strong political, social, and economic opposition, four Republican governors chose to fully expand Medicaid eligibility under the ACA. Using the case study method and qualitative content analysis, the purpose of this research is to explore the rhetoric and language by these four Republican governors despite party-wide opposition to the expansion and to the ACA overall. The results of this study found that three major themes emerged: advocacy for the disadvantaged, an argument for fiscal responsibility, and an appeal to rationality. Though each governor faced unique social, political, and economic conditions that may have contributed to their decision to expand, all four governors framed their decision as a means of aiding those in their state who would benefit most from it. As neither politics nor policies exist in a vacuum, the results of this research further support the need for thick, contextual analysis of gubernatorial decision-making and the impact of language and rhetoric on the success of their policies.

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CHAPTER 1

INTRODUCTION[1]

The history of health care legislation in the United States is as complex and varied as those who call themselves American. The passage of the Affordable Care Act in 2010 is arguably one of the most significant pieces of health care legislation passed in the United States in the past half-century (Musumeci, 2012) and considered by some scholars to be the magnum opus of President Obama's presidential legacy (Daschle, 2017). However, the development and implementation of the Affordable Care Act (ACA) was not without complication; in the months leading up to the final passage of the ACA, lengthy congressional discussions and bipartisan debates were held to discuss the details of the bill. The bill was passed without support from the Republican party and was vocally opposed by leaders from the Republican party as well as political pundits, medical professionals, and others (Pierson, 2016). Some of the arguments that opponents used typically focused on opposition to the individual mandate, the potential of rising tax burdens on the public, and the overreach of federal power on states' rights and choices (Musumeci, 2012). While there have been numerous critiques of the ACA overall, the expansion of Medicaid eligibility requirements has led to continuous social, financial, and moral debates surrounding the role of government intervention, political partisanship, and state autonomy in health care legislation and health services implementation.

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[1] Portions of this chapter were also published in: Arguelles, A. and Sabharwal, M., "Health Care for All: An Overview of the Affordable Care Act's Medicaid Expansion in the USA", Indian Journal of Public Administration pp 142-172. Copyright © 2018 Sage Publications. https://doi.org/10.1177/0019556117750895.

Since its passage in 1965, Medicaid has served as the primary health care coverage for millions of underserved, low-income individuals (Medicaid.gov, 2017). Medicaid coverage typically includes pregnant women, children, older adults, and those with disabilities under a certain income level (Goodnough and Zernike, 2017). Despite multiple budget cuts, a rising federal deficit, and increasing partisan divides on the role of governmental intervention in personal and state choice, Medicaid funding has largely retained its protected status as a social benefit program (Pew Research Center, 2013; Callahan, 2011). With few exceptions, states that opposed the Medicaid expansion from the ACA were led by Republican governors (Stolberg, 2017). Several states argued that the financial burden to tax payers would be too high; though the federal government would initially cover the cost of the expansion, some governors did not trust that this promise would be upheld (Malloy, 2012). Others argued that along with the costs, they would rather delay the decision to expand Medicaid pending the results of the 2012 election in the hopes of that the then-Republican Presidential nominee Mitt Romney would undo the ACA all together (Pear and Cooper, 2012 and Padgett, 2012).

Nevertheless, the decision of the 2012 Supreme Court case resulted in four Republican governors choosing to fully expand Medicaid. Though several Republican governors have chosen to expand via Section 1115 waivers (Weil, 2012), as of this writing there are sixteen states who have not expanded with seven of these still in consideration. Almost a decade following the ACA's initial implementation, the possibility of expanding Medicaid has remained a heavily contested battle in states around the country (Goldstein and Vozzella, 2018 and Levey, 2018). Though the rise of political partisanship can serve as a clear indicator for which state would be more likely to expand Medicaid (Keepnes, 2014, Callaghan and Jacobs, 2016 and

Grogan and Park, 2017), the role of a governor serves as an interesting comparison. Previous research into gubernatorial decision-making has illustrated that governors have unique pressures throughout their tenure; personal ideology, national politics, and mixed state legislatures are just some of the many factors that a governor must navigate (Flagg, 2016).

Therefore, the purpose of this research will be to explore the social, economic, and political conditions of four states with Republican governors that chose to expand Medicaid under the ACA (Nevada, New Mexico, North Dakota, and Ohio) – with the primary research question asking: What were the most prevalent, consistent explanations and factors – as given by their governors – that contributed to the passage of the ACA's Medicaid expansion in these states? Using a case study (Creswell, 2007) and qualitative content analysis (Schreier, 2013), this research will explore the rhetoric, themes, and descriptors used by these Republican governors in articulating their decision to expand Medicaid. The secondary purpose of this research will be to provide a thick, contextual description of the events and timeline of the Medicaid expansion, the political environment that the Governors and their states were in, and relationship that these governors had with their state legislators and constituents. Thus, this research will be divided into the following sub-chapters: the remainder of Chapter 1 will provide a brief history of health care policy development in the United States, with a discussion on the development of the Affordable Care Act. Chapter 2 will discuss the background, implementation, and opposition to the Affordable Care Act and Medicaid expansion, providing a framework for understanding the political and social environment that the governors lived in. Chapter 3 will describe the research methodology for this study with a description of the data collection methods. Chapter 4 will explore the results of the case study and qualitative content analysis of the four governors'

speech and rhetoric concerning their intention to and reasoning for expanding Medicaid. Chapter 5 will discuss states who chose to expand before being limited by political, social or other issues, to serve as a comparative analysis for the results of the previous chapter. Chapter 6 will conclude this research with a summary of findings, a discussion of limitations, and potential avenues for future research.

BACKGROUND

The history of health care legislation in the United States is fraught with political infighting, public backlash, and begrudging acceptance as seen through the managed care backlash of the 1990's (Mechanic, 2004), the failed Clinton health care bill of 1993 (Webber, 1995), and the many debates surrounding health care reform during President George W. Bush's second term as President (Mechanic, 2004; Carroll, 2007; Price et al., 2006; Reinhardt, 2006). Although the full history of health care reform in the United States is beyond the scope of this dissertation, briefly exploring this history provides context for the complex role the development, passage, and implementation of the ACA. Although there are several environmental, political, and social factors that contribute to the process of health care reform in the United States, the following provides a brief history of successful legislation that has been implemented towards the delivery of health coverage to the disenfranchised.

Health Care Policy in the Pre-Modern Era

The Progressive movement of the early 20th century spread into many aspects of daily life, including health care policy. Although recent history suggests health policy reform has been a modern trend for election campaigns, vocal support for President Theodore Roosevelt's second campaign came from progressives who supported universal health coverage (Wilson, 1993),

drawing comparisons from the social policies of their foreign counterparts. However, the American Medical Association (AMA) – and many within the public – were vehemently opposed to the idea of government-led, universal health insurance. Although there are many potential reasons to consider why Roosevelt's campaign ultimately failed, the opposition to his stance on universal health coverage could be attributed to the deep-seated beliefs in a decentralized national government, rooted in a mistrust of a federal government with too much overreach (Morone, 2010).

The argument for universal health coverage emerged again following the Great Depression and again after the Second World War. President Franklin D. Roosevelt's Social Security Act of 1935, a result of his proposed 'New Deal', developed the Social Security program which became the primary source of income for the elderly (Marmor, 1996). Similar to the New Deal, President Truman proposed the 'Fair Deal' in 1949 which aimed, among other goals, to provide funding and services to millions of uncovered Americans (Marmor, 1996). Although public opinion was split on the proposal with 38 percent opposing and 38 percent in favor, AMA opposition remained strong (Harrison, 2003). Considered to be their most expensive lobbying campaign at the time, the AMA widely opposed Truman's 'Fair Deal', calling it both 'un-American' and 'socialized medicine' (Zelizer, 2015). The AMA furthered their distaste for the proposal by claiming that members of the Truman administration were 'followers of the Moscow party line,' a damning critique for a president during the initial stages of the Cold War (Markel, 2014). Politically, members of Truman's own party were opposed to the expansion as some Southern Democrats feared that the proposal would cause the desegregation of hospitals (Abundis and Butler, 2012). Although the Fair Deal was ultimately a failure, this and the Social

Security Act of 1935 before it, set the foundation for the Social Security Amendments of 1965, leading to the establishment of Medicare and Medicaid (Igiede, 2010), a means of providing health coverage to the most disadvantaged within the United States [2] [3].

Public support for universal health coverage in the United States remains a hotly contested topic, with recent polls being mixed and largely driven by partisan influences; while 52 percent of Democrats and 12 percent of Republicans support universal health coverage, only 33 percent overall believe the federal government should be fully responsible for the implementation and delivery of health care (Kiley, 2017). However, historical support for Medicaid has remained relatively stable as Americans tend to recognize the importance of providing health coverage to the disadvantaged as the effects of these interventions are both personal and widespread (Cohen et al., 2015).

Medicaid in the Modern Era

Unlike other healthcare systems, the United States has no formal, central governing agency to determine, moderate, and develop legislation specifically for healthcare. Federal and state governments work in collaboration with each other through licensing, certification, and in many cases, patchwork legislation (Cannon, 2013). As of the late twentieth century, insurance companies act as intermediaries for financing and delivery for most individuals (Stolfzfus Jost, 2012). For many in the United States, the payment of health care is delivered through insurance

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[2] Medicare is a federal health insurance program for older adults, young people with disabilities & people with End-Stage Renal Disease. https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html.

[3] Funded by both federal and state governments, Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. https://www.medicaid.gov/medicaid/index.html

companies, paid either privately or through their employer (Stolfzfus Jost, 2012). However, for over 70 million individuals in the United States, Medicaid is the primary source of coverage for their health care needs (Paradise, 2015).

Medicaid is the largest publicly funded health insurance provider in the United States, covering families with low-income, pregnant women and their children, and individuals who are permanently disabled (Medicaid.gov, 2017). Created in 1965 as part of the Social Security Act, Medicaid was originally conceived as a state-federal cash assistance program through the Aid to Families with Dependent Children (AFDC) welfare program to assist the coverage of medical expenses for "aged, blind and disabled individuals and parents and dependent children receiving public assistance" (Paradise, Lyons, and Rowland, 2015). At the time of its creation, Medicaid was framed as a way for states to have independence in creating medical assistance programs (ASPE, 2005). Though a voluntary program, all 50 states have elected to participate in Medicaid (Paradise, Lyons, and Rowland, 2015).

As a public insurance program, Medicaid covers multiple health care services for the populations it represents including hospital visits, home health and laboratory services, transportation to medical care, family planning and more (Medicaid.gov, 2019). States are required to cover children and pregnant women up to at least 138 percent of the federal poverty level (FPL) and individuals with disabilities (Altman and Frist, 2015). Once the minimum federal standards have been met, states have had considerable freedom to determine "how the program is administered, who to cover, what services to cover, and how providers are paid" (NCSL, 2018). However, these requirements have evolved slowly over time, through the work of both Congressional and state lawmakers.

Originally, states were required to allow poor single parents and children receiving welfare to receive Medicaid – originally 50 percent FPL (Paradise, Lyons, and Rowland, 2015). While some states chose to further expand eligibility to low-income families, each state had flexibility in how they determined who was able to receive Medicaid. Following the Social Security Amendments of 1967, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was created. A provision that emphasizes preventative health care coverage, EPSDT is a comprehensive health insurance package for children under the age of 21 (Medicaid.gov, 2019). In the 1980s and 1990s, Congress raised eligibility thresholds to ensure that children in families with income up to 100 percent FPL were covered, ensuring that children in poverty were receiving health care coverage (Paradise, Lyons, and Rowland, 2015).

Following the creation of the Supplemental Security Income (SSI)[4] program in 1972, many states linked Medicaid eligibility with SSI eligibility (ASPE, 2005). However, this linkage led to a considerable coverage gap; Medicaid enrollment for children in poverty declined from the 1970s and into the 1980s because of the decline in AFDC eligibility (Mann, Rowland, and Garfield, 2003). It wasn't until the Temporary Assistance for Needy Families (TANF) welfare overhaul was passed that welfare and Medicaid eligibility were separated (Paradise, Lyons, and Rowland, 2015). This separation drastically changed the nature of the Medicaid program from a cash assistance program to the health coverage program it is considered today (Paradise, Lyons, and Rowland, 2015).

[4] The Supplemental Security Income program was a federally-funded income assistance program for older, low-income, and disabled individuals. (Social Security, 2018).

Though the expansion of health care coverage for children and the parents of low-income children has evolved over the time, public health care coverage for childless adults in poverty has been historically limited (Altman and Frist, 2015). Prior to the implementation of the ACA, non-elderly, childless adults with low-income had few options in enrolling into public health insurance creating a coverage gap that the Affordable Care Act's Medicaid expansion aimed to fill (Garfield, Damico and Orgera, 2018). Unlike its Federal counterpart Medicare, the publicly funded healthcare provider for individuals over the age of 65 and or with permanent disabilities (Cubanski et al., 2015), enrollment in Medicaid has held a long history of stigma. This could potentially be attributed to its traditional linkage with welfare programs, as the perception of those who enroll into welfare-like programs are often perceived to be lazy or have some form of moral failing (Cohen, 2017 and Thompson, 2018). For recipients of Medicaid, there can be a perception that the health care provided is significantly less valuable in quality than private insurance (Barr, 2000 and Ketsche et al., 2007).

Despite the misconceptions of Medicaid's coverage and its recipients, Medicaid as a governmental program has remained largely protected despite multiple budget cuts and a rising federal deficit (Pew Research Center, 2013). Following the 2008 financial recession, policymakers worked towards implementing cost-effective policies that would invigorate the current market while eliminating potential fiscal issues in the future. Although Medicaid is one of the highest funded programs within the federal budget, conversations around cutting funding towards Medicaid have been likened to committing political suicide (Callahan, 2011). This may be due in part to the broad support that Medicaid has held over the past few decades.

In a 2018 poll by the Kaiser Family Foundation, seven in ten Americans stated that they had a connection to the Medicaid program either personally for themselves or their children, to a friend or family member that is covered by the plan (Kirzinger, Wu, and Brodie, 2018). Medicaid has maintained strong support among the constituents it benefits the most: children with special health care needs, older adults, and individuals with disabilities (Rudowitz and Garfield, 2018).

As defined by the U.S. Department of Health and Social Services, children with special health needs are "at increased risk for chronic physical, developmental, behavioral, or emotional conditions and also require health and related services of a type or amount beyond that required by children generally" (HRSA, 2018). For many of these children, Medicaid bridges the gap in providing access to vital health care services that they would otherwise be ineligible for from private insurance companies and at a rate that's affordable for the families involved (Musumeci and Foutz, 2018). Although medically necessary services are mandated under EPSDT, states who decide to make home and community-based long-term care services optional under Medicaid disproportionately affect children with special health needs (Center for Budget and Policy Priorities, 2018). For older adults, Medicaid aids in covering long-term services and supports (LTSS) that aren't covered through Medicare; though each state has flexibility in how these benefits can be doled out, LTSS such as nursing facilities and home health services are generally considered to be covered (Kaiser Family Foundation, 2016). Finally, individuals with disabilities tend to have greater health needs and have greater limitations in accessing health care services. Many of the services that that individuals with disabilities require such as habilitative services, assistive technology and supportive housing services are not available through private

insurance but are through Medicaid. This allows individuals with disabilities to not only receive the health care coverage that they need but facilitates their ability to live independently within their own communities (Musumeci and Foutz, 2017). While fiscal analysts from both ends of the American political spectrum have expressed their concerns on the rising costs of health care in the United States (Bera and Paulsen, 2017), Medicaid spending has remained relatively untouched as the social and political consequences of cutting the program would be considered too volatile.

Previous attempts to reduce the cost burden for health care in the United States have been fraught with complications as the backlash for some of these initiatives was so severe, the proposed reforms were either replaced or removed altogether (Mechanic, 2004). This rising cost burden and the unwillingness to have conversations surrounding the rationing of health care services (Robinson, 2001) is exacerbated with the United States' heavy investment in medical technology. As seen in Figure 1, per-capita health care spending in the United States is 42 percent higher than Luxembourg, the next highest per-capita spender (Kaiser Family Foundation, 2012). A study in 2017 by the Global Burden of Disease Health Financing Collaborator Network found that the United States continues to hold its rank as the highest payer of health care per-capita at $9,237 (Brink, 2017).

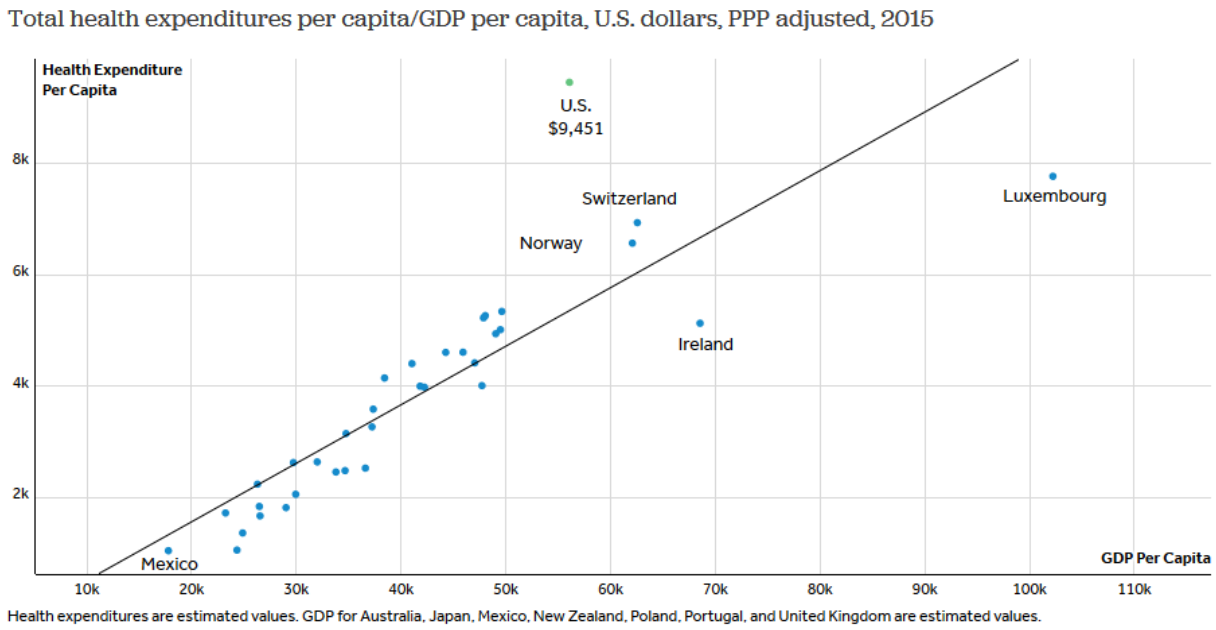

Figure 1. Total Health Expenditures per capita/GDP per capita, U.S. Dollars, PPP Adjusted, 2015. *Kaiser Family Foundation*, 2015

Overall, the United States spends over 17 percent of its GDP on health-care related expenditures, compared to the average of 11 percent of its foreign counterparts (Kaiser Family Foundation, 2012). While healthcare costs continue to rise, the quality of healthcare remains uneven; despite having the most updated, innovative technology, health care quality in the United States is largely unequal as the United States has lower life expectancy and morbidity rates compared to its foreign counterparts (Kaiser Family Foundation, 2012).[5] This is compounded with many Americans having a contentious, if almost skeptical relationship with physicians, hospitals, and

[5] In the US, life expectancy is 78.8 years. CDC, *National Center for Health Statistics.* https://www.cdc.gov/nchs/fastats/life-expectancy.htm.

the overall health care system, particularly from minorities (Schnittkker, 2004 and Hausman et al., 2011).

According to the International Social Survey Programme, Americans rank 24th of 29 countries observed in terms of public trust regarding their physicians (2013), while simultaneously ranking 3rd of 29 when asked about personal satisfaction with their own medical treatment (Blendon, Benson, and Hero, 2014). Similarly, a Gallup poll indicated that only 23 percent of Americans felt confident about the overall health care system (2014). This is typical of the cognitive dissonance that Americans share concerning their long-standing mistrust of public institutions and of those in power; Americans may have a significant distrust of Congress overall yet like their own representatives (Norton, 2014). This seemingly hypocritical stance of Americans towards the health care system and the services it provides illustrates just one facet of the multiple issues policymakers confront when attempting to institute health care reform. The following chapter will briefly discuss the development of the Affordable Care Act, a description of what the expansion of Medicaid eligibility entailed, and the resulting Supreme Court case. This will be followed with a discussion of the views and perceptions of the Medicaid expansion, the arguments against pursuing the expansion, and a literature review containing previous research on gubernatorial decision making concerning the expansion. This will serve as a foundation to further explore the purpose and discussion of this research.

CHAPTER 2

THE IMPLEMENTATION AND OPPOSITION OF THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION[6]

The Development of the ACA

Like many elections before it, the 2008 Presidential election brought healthcare to the center of debate, with each Presidential candidate expressing that healthcare in the United States "must change" albeit each having his own interpretation of how to do so (Blendon et al., 2008). In the months leading up to his election, President Obama promised to "fix" healthcare in the United States and his following tenure showed his commitment to doing so (The New York Times, 2008). Signed into law in March of 2010, the purpose of the Patient Protection and Affordable Care Act – colloquially nicknamed the Affordable Care Act (ACA) and later, Obamacare – was multifold; the ACA aimed to lower the overall uninsured rate, increase healthcare quality, and simultaneously control and lower the cost of healthcare (Kocher, Emanuel, and DeParle, 2010). The development of the ACA was a result of months of research, planning, and bi-partisan discussions that resulted in multiple compromises (Politifact, 2017).

These compromises were not without complication as many Republican lawmakers were vehemently opposed to much of the bill's provisions. Journalist Steven Brill has analyzed the obstacles that arose throughout the development, passage, and implementation of the ACA. Brill (2015) argues that a combination of partisanship driven opposition, negative framing tactics used

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[6] Portions of this chapter were also published in: Arguelles, A. and Sabharwal, M., "Health Care for All: An Overview of the Affordable Care Act's Medicaid Expansion in the USA", Indian Journal of Public Administration pp 142-172. Copyright © 2018 Sage Publications. https://doi.org/10.1177/0019556117750895.

in mass media, and failed negotiations with industry leaders led to its contentious implementation, although the research and discussion surrounding the ACA's passage and implementation will continue for years to come.

The Medicaid Expansion Backlash

An original component of the ACA, the expansion of Medicaid eligibility proclaimed that all individuals with incomes at or below 138 percent of the poverty level would be eligible for Medicaid by 2014 (Musumeci, 2012). At its original writing, the expansion of Medicaid was a mandate by the federal government that required states to participate in the program lest they forgo all funding for Medicaid (Musumeci, 2012). In doing so, the ACA aimed to not only expand health coverage through Medicaid to disadvantaged and low-income populations, but to non-elderly childless adults – a group that has historically been shut out of Medicaid coverage (Paradise, Lyons, and Rowland, 2015). Additionally, the ACA's Medicaid expansion raised the eligibility threshold for school-age children, extended Medicaid coverage for foster care children up to age 26 and mandated for states to streamline the application process (Paradise, Lyons, and Rowland, 2015).

Prior to the Medicaid expansion, enrolling into Medicaid was similar to the application process for cash welfare programs (Kaiser Family Foundation, 2018). As shown in Figure 2., the modernization of applying for Medicaid was meant to reduce the number of individuals uninsured, alleviate administrative burdens on states, and facilitate access to coverage using technology. According to the original mandate of the ACA, the process for Medicaid application was established to: "(1) provide a single, streamlined application for Medicaid, CHIP, and Marketplace coverage that individuals can submit online, by phone, in-person, and or mail, (2)

eliminate the use of asset tests for groups eligible through income-based eligibility pathways, (3) eliminate in-person interview requirements, (4) utilize electronic data matches to verify eligibility criteria to the greatest extent possible, only requesting paper documentation when they were unable to obtain information electronically, (5) renewals could not be completed more than once every year for groups eligible through income-based eligibility pathways, and (6) must renew coverage based on information from available data sources before requesting information from the individual" (Kaiser Family Foundation, 2018).

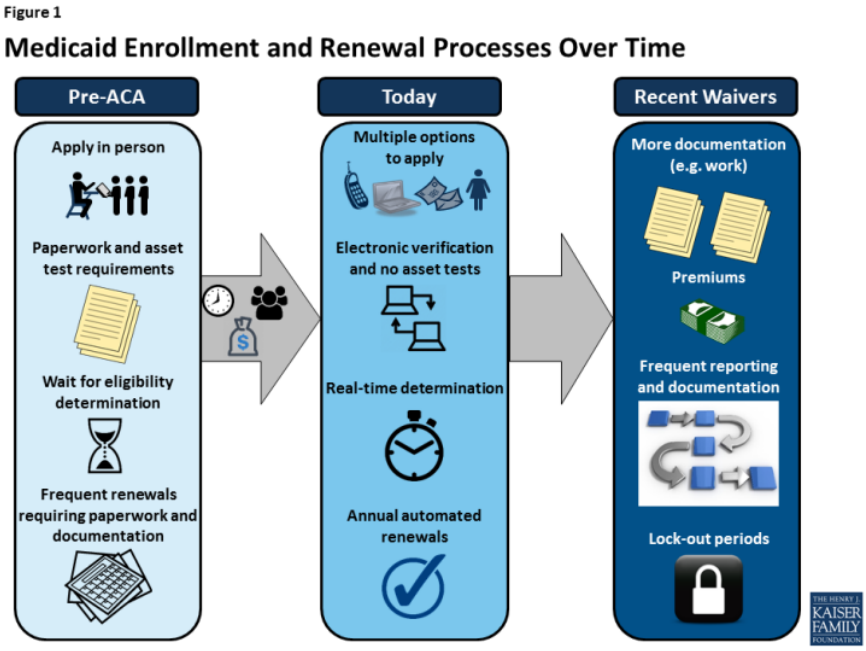

Figure 2. Medicaid Enrollment and Renewal Processes Over Time. *Kaiser Family Foundation*, 2018.

According to the Congressional Budget Office in 2012, the Medicaid expansion would increase coverage for up to 17 million people by 2020 (Musumeci, 2012). Advocates for the expansion of Medicaid praised the increase in insurance coverage, seeing it as an improvement on the current system (Sullivan, 2010 and Freudenheim, 2010). Additionally, the financial

benefits in expanding Medicaid were praised among supporters as funding for the expansion would pay 100 percent of Medicaid costs from 2014 to 2014 (Viebeck, 2012). This match would gradually decrease to 90 percent by 2010 but would remain consistent in the years following (Snyder and Rudowitz, 2015). In addition to the support of budget analysts and advocacy groups (Erwin, 2010 and Lazarus and Lithwick, 2011), there was particularly strong support among the public and physicians in rural areas, where the possibility of increasing funding for these areas would likely receive the greatest benefit (Roy, 2011 and Kavilanz, 2010).

Nevertheless, the backlash against the Medicaid expansion was swift and widespread from policymakers and several conservative think-tanks (Pipes, 2015; Leonard, 2015; Musumeci, 2012). Although the uninsured rate dropped from 18 percent to 13.4 percent in less than a year (Dalen, Waterbrook, and Alpert, 2015), negative views and perceptions of the ACA were abundant, as a result of attack advertisements and misinformation on what the ACA's components included (Kessler, 2014 and Gonyea, 2017). While scholars have argued that the vehement opposition of such a widespread health care reform was a result of racist ideologies (Fraser, 2009; McCamey and Murty, 2013; Brown, 2011; Kennedy, 2011), many who opposed the ACA argued that the multiple economic and social concerns were the predominant motivation for the backlash. These concerns – and others – will be further explored in the literature review of this chapter.

In 2013, the Galen Institute, a non-profit health and tax policy organization proposed that while there were good intentions with the idea of expanding Medicaid, the actual enforcement and mandatory expansion would put already at-risk patients even more at risk as states struggled to pay for those already under the Medicaid program (2013). Similarly, opponents argued that

the quality of service given under Medicaid, already in a poor state, would only increase leading to longer wait-times in hospitals and less access to personal physicians (Viebeck, 2013). These concerns were validated in a study published by Baicker et al. that evaluated the 2008 Medicaid expansion in Oregon which found that increased Medicaid coverage saw no significant improvements in measured physical outcomes in the two years studied (2013).

Others argued against the risk burden that would inevitably be placed on taxpayers; while the program would be initially 100 percent covered by the federal government until 2016, the gradual decrease in Federal support to 90 percent to 2020 (Musumeci, 2012) and its continued descent in the following years indicated that the full-burden would eventually rest on the individual state's tax base (Pipes, 2015) especially as some governors did not even trust the Federal government to share the burden for the promised time (Leonard, 2015). As the cost of healthcare continued to rise, opponents argued that the expansion of Medicaid would not control for these costs but lead to their increase. A report from the Moody's Investors Service found that while nonprofit hospitals such as Southern Illinois Healthcare saw their unpaid bills drop by $9 billion, the hospital still lost $5 billion from surging Medicaid costs (Weaver, 2015).

Alongside economic concerns, opponents also argued against the social costs of the expansion of Medicaid. A working paper by Burns et al. (2014) argued that expanding Medicaid enrollment would lead to long-lasting negative effects on unemployment for childless adults, de-incentivize workers to search for paid positions as this would result in the loss of their Medicaid coverage (Burns et al., 2014; Chen, 2014; Archambault, 2015; Ku and Brantley, 2017) and lower positive health outcomes (Belluck, 2012). Others argued that the mandatory implementation of the expansion – at the risk of losing all funding for Medicaid – was at best, part of an

overarching mission to embed a socialistic ideal of payment in the health care sector (Pipes, 2015) and at worst, un-constitutional as it superseded state sovereignty (Matthews, 2012). This last argument was a partial impetus for the Supreme Court case against the ACA, which is discussed below.

National Federation of Independent Business v. Sebelius, 2012

Though generally linked to opposition to the individual and employer mandate, National Federation of Independent Business (NFIB) v. Sebelius was also filed against the enforced implementation of expanding Medicaid eligibility (Cornell Law, 2013). A coalition of 25 states, many of which were in the Midwest and Southern regions of the United States (Figure 3), filed a lawsuit against the enforcement of the Medicaid expansion arguing that attaching the condition for continued Federal funding for Medicaid was unconstitutional (Russell, 2012).

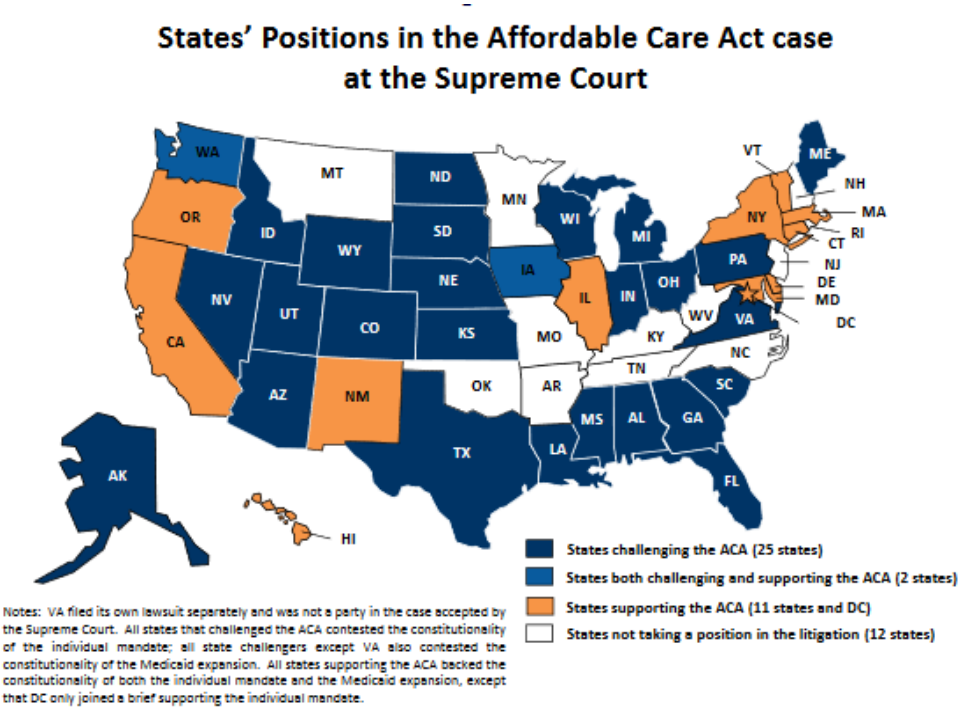

Figure 3. States' Positions in NFIB v. Sebelius, *Kaiser Family Foundation.* http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-affordable/.

The lawsuit argued that the US Constitution doesn't authorize "to mandate either directly or under threat of penalty, that all citizens and legal residents have qualifying health care coverage" (CNN Wire Staff, 2010). Though ordered by mostly Republican attorney generals, supporters of the lawsuit argued that this was not a partisan struggle; rather it was a fight against federal supremacy over state sovereignty (CNN Wire Staff, 2010). In the months preceding the 2012 Supreme Court ruling, several Republican governors commented on the possibility of expanding Medicaid. While some such as Rick Perry of Texas were adamant in their refusal (Ramshaw, 2012), the governors of Virginia, Wisconsin and Louisiana indicated their intention to wait for the upcoming 2012 election before making their decision (Tumulty and Vozzella, 2012 and Pear and Cooper, 2012).

While much of the legislative battle for this lawsuit revolved around the individual and employer mandate for health insurance (Musumeci, 2012), the decision on the expansion of Medicaid provided a new precedent for understanding the relationship and limitations of federal power (Adler, 2014 and Solum, 2013). Prior to *NFIB v. Sebelius*, the Supreme Court had previously supported the Federal government's right to attach conditions to its funding mechanisms so long as it upheld four major functions: "it must be (1) related to the general welfare, (2) stated unambiguously, (3) clearly related to the program's purpose, and (4) not otherwise unconstitutional" (Musumeci, 2012). Yet the ruling of *NFIB v. Sebelius* stood as the first time Supreme Court justices ruled against the Federal government, largely because states were not given adequate time to consent to the bill voluntarily and the exclusion of all Medicaid funds as a penalty for lack of consent was deemed to be unconstitutional (Liptak, 2012). The final decision allowed the ACA Medicaid expansion to be upheld but its mandate became

optional; states that chose not to expand Medicaid eligibility would not be penalized by losing all Medicaid funding but would only lose out on funding specifically given towards the ACA's Medicaid expansion (Musumeci, 2012).

Preliminary Effects of the Medicaid Expansion

The long-term effects of the expansion of Medicaid eligibility for states would be difficult to determine as the strength of any impact would need to be observed years, if not decades, following the implementation of the expansion. However, in a report published by Antonisse et al. (2018) with the Kaiser Family Foundation, the authors summarized the findings of 108 studies on the impact of ACA Medicaid expansions from January 2014 to January 2017. Using government sources, free-standing reports, and 'white papers' from research and policy organizations, the study aimed to examine the impact of the Medicaid expansion for states that did and did not choose to use the ACA Medicaid expansion under three broad categories: the effect the expansion of Medicaid had towards overall coverage, its use in improving access to care, utilization, affordability, and health outcomes, and the economic results of this expansion for the states observed (Antonisse et al., 2018).

The results of their study found that the expansion of Medicaid significantly increased health care coverage of the low-income population, both broadly and for specific vulnerable populations (Antonisse et al., 2018). The report also found that research studies which evaluated access to care, utilization of services, and affordability of health care services were positively affected by the ACA's Medicaid expansion. Though self-reported positive outcomes were also high, Antonisse et al. (2018) believed more research was needed to determine how much these self-reported outcomes affected long-term health outcomes. Finally, the report found that while

Medicaid enrollment growth was initially projected to negatively affect the economic conditions of the states, the reports analyzed found the opposite of this with the Medicaid expansions resulting in reductions for uncompensated care costs and "positive or neutral effects on employment and the labor market" (Antonisse et al., 2018).

Contrary to popular belief, patients' perception of quality of care also changed as many low-income patients preferred their coverage and treatment from Medicaid compared to private insurance (Sanger-Katz, 2014). An analysis of the 2015 National Health Interview Survey found that the perception that Medicaid coverage would increase the number of working-eligible adults who would refuse employment as a means of maintaining Medicaid coverage was refuted, as 48 percent of those covered by Medicaid were "permanently disabled, have serious physical or mental limitations… or are in fair or poor health" (Ku and Brantley, 2017). Of the 25 percent of individuals who were not working or in school, the report found that many were able to use tax credits and cost-sharing reductions to make the transition from public to private coverage (Ku and Brantley, 2017).

Considering these results, it's not surprising that a poll conducted by the Kaiser Family Foundation as early as 2011 found that 47 percent of those observed did not wish for Medicaid spending to be reduced (Kaiser Family Foundation, 2011) with 39 percent believing Medicaid spending to be of 'personal importance'. As of February 2018, 56 percent of individuals who lived in states that did not expand Medicaid believed that their state should cover more of the low-income uninsured (Kirzinger, Wu and Brodie, 2018). However, these results were mixed when linked towards political identification; of individuals observed in non-expansion states, only 39 percent of Republicans believed their state should expand the Medicaid program while

75 percent of Democrats believed the same (Kirzinger, Wu and Brodie, 2018). Though the effect of partisanship and political identification in relation to support for the Medicaid expansion will be discussed in later in this chapter, the significance of these findings illustrate the importance of understanding the framing, ideology, and politics of the Medicaid expansion. While exploring these issues can be important in and of itself, disentangling the variety of factors, reasons, and ideology towards the support of and opposition of the Medicaid expansion provides an interesting, relevant case study to explore. The following section teases out some of these issues and lays out the foundation for understanding why qualitative content analysis – the intended tool for this case study exploration – can lead to a better understanding of the context, environment, and situation of Republican-led governors who acted contrary to national politics.

LITERATURE REVIEW

The severe opposition surrounding the Medicaid expansion could be attributed to several factors related to cultural, social, and racial attributes of elected officials and their constituents. Dolgin and Dietrich (2011) sought to uncover the social and legal complications of the ACA overall, which can be used as a foundation toward understanding the mechanisms used to oppose/support the ACA's Medicaid expansion. In their research, the authors found that opposition to the bill was grounded in three major factors: 1) social class resentment, 2) political conservatives opposing federal overreach, and 3) negative racial attitudes and biases.

For the first, the authors described the sense of superiority found within the public and their resentment at being labeled equal to the lower socio-economic populations in the United States; using health care status as a proxy for evaluating economic and social class, the public was opposed to the concept of the ACA – much less the Medicaid expansion. These groups

argue that those with low-economic status deserve to be without healthcare due to their laziness and lack of upward social mobility (Dolgin and Dietrich, 2011). The authors argue that if individuals see their health status as a reference to class, the expansion of health coverage becomes threatening to those individuals' sense of moral and social worth.

For the second, the authors observed that political conservatives – advocates of market-based solutions, state autonomy, and individual choice – were alarmed at the far-reaching implications of the ACA and how this would usurp the role of the individual in the health care decision-making process. Similar to the points made in the first point, the authors argued that some of these conservative arguments bled into rhetoric against the poor; opposing the ACA was not just a result of it being antithetical to conservative policy ideals, but rather their opposition was rooted in rhetoric that assumes the poor has failed to make the "right" choices to alleviate their poverty and poor health status. Using this logic, the opponents then argue that the expansion of health coverage to all would be an assault to true political freedom (Dolgin and Dietrich, 2011).

Finally, the authors described what they referred to as extremist opposition to the ACA, which manifested itself in violent and intrinsically racist depictions of the ACA and of President Obama himself. This was concluded with the authors' assumption that views of the ACA could be a Rorschach test for how people understand their own personhood, community, and national identity. These conclusions illustrate the power of personal ideology in supporting and opposing the ACA overall. Analysis of the arguments concerning the ACA and Medicaid expansion thus cannot ignore social and political rhetoric as this would diminish its interpretation (Hero and Tolbert, 1996). Although no policy exists in a vacuum, the language used to describe the ACA's

Medicaid expansion would benefit from a deeper, contextual analysis of these words and their meanings.

Furthering this look into views regarding the ACA's Medicaid expansion, Barrilleaux and Rainey conducted research on who most likely would be opposed to the Medicaid expansion (2014). While they hypothesized that both political demands and health coverage needs[7] of the population would significantly contribute to the governor's decision-making process, the authors found that it was primarily political partisanship that had the most significant effect on their opposition, as level of coverage need within the state had a near negligible effect. The significance of political partisanship in policy decision-making and its eventual impact towards elected officials' decision-making thus supports the gravity of Republican-led governors acting against the prevailing opinions of their party.

Research by Flagg (2016) also explored the role of decision-making among governors regarding the Medicaid expansion. Using a mixed method methodology, Flagg found that while many factors contributed to the governors' decision-making process, electoral pressure was the most statistically significant. Other factors observed such as economic concerns, existing history of expanding Medicaid, the role of stakeholders, and the governor's personal beliefs were also found to be statistically significant. Seeing to expand these results through a case-study, Flagg completed content analysis of newspaper coverage, political speeches, press releases and

[7] As a key goal of the ACA was to reduce the percent of those uninsured, states that did not expand Medicaid would be placing an increased burden on their not-for-profit hospitals which would provide more uncompensated care than for-profit hospitals. Therefore, states with a larger uninsured population would stand to benefit more from expanding Medicaid compared to states with a smaller uninsured population.

interviews from key informants such as journalists, researchers, and staff members of both Governor Scott Walker of Wisconsin and Governor John Kasich of Ohio. Through this methodology, Flagg found that in the case of Governor Kasich – a Republican who chose to expand Medicaid – the factors found to be significant appeared to provide justification for the change rather than contributing to the decision-making process (Flagg, 2016).

Tying these studies together, the work of Lanford and Quadagno significantly contributed to the impetus for this research as their study examined factors that may have explained the variation of implementation for the Medicaid expansion among all 50 states (2016). In their analysis, the authors evaluated each state's Medicaid policy legacy, the influence of providers, the effect of partisan politics, the prevalence of conservative ideology, racial resentment among the public, and the state's fiscal capacity as a means of predicting whether a state would expand Medicaid. Based on the results of their study, Lanford and Quadagno confirmed that partisan power, policy legacy, provider influence, and public ideology were statistically significant towards a state's expansion (2016). Additionally, though not statistically significant, the authors found that states with lower racial sympathy and higher racial resentment showed a stronger resistance to the Medicaid expansion on average while state fiscal capacity had a negligible effect (Lanford and Quadagno, 2016).

Using the above research as a foundation, the following will further explore the ACA's Medicaid expansion through three lenses: 1) the effect of partisanship on state level decision making, 2) the effect of social class opposition, and 3) the role of racial rhetoric.

Partisanship and Policymaking

In the political and social sciences, there is a long-standing debate on what effect – if any – partisanship has on state policymaking. Research by Fiorina and Adams argued that the effect of partisanship is less of a representation of the electorate, but rather a fixture of the political elite (2008). In their research, the perception of extreme partisanship has been exaggerated as the average 'median' voter is bound to be more moderate than the political elite. Additionally, the Pew Research Center found that while the public's perception of polarization may have increased, this may rely more on the relationship of news sources contributing to – and in some cases inciting – this type of division (2016).

Others have argued that partisanship – for both the political elite and the electorate – not only effects how policies are formed and received, but this effect is increasing. As discussed by Green, Palmquist and Schickler, the perceived decline of political institutions should not be viewed as a proxy for the decline of political partisanship but rather as an entity that describes personal identification. Despite rising mistrust of political establishments (Friedman, 2017; Malone, 2016; Millman, 2017), the attachment to a partisan group can become an object of social identification like that of a religious identity. As noted in their research, "when people feel a sense of belonging to a given social group, they absorb the doctrinal positions that the group advocates" (Green, Palmquist and Schickler, 2002). Similarly, the act of social sorting – division of individuals based on their racial, religious, and political identity – can drive partisans to react more emotionally to political messages (Mason, 2016) with research by Huddy, Mason and Aaroe arguing that when the status of a party is threatened, the strongest emotion exhibited is anger (2015). This can help explain the extreme reactions found among partisans, with research

by Mason and Wronski arguing that as racial, religious, and ideological identities have become more aligned with the two major political parties, the public has become "increasingly identified with their parties due to the psychological effects of identity alignment…," with this effect being more powerful among Republicans compared to Democrats (2018).

However, it would be disingenuous to assume that this effect is only found among right-leaning conservatives. As discussed in their work *Party in the Street: The Antiwar Movement and the Democratic Party after 9/11*, Heaney and Rojas found that Democratic opposition to the Iraq War was less based on ideological identification with the anti-war movement, but rather with extreme opposition toward President George W. Bush and the Republican party (2015). By aligning with the anti-war movement, a social movement that can be traced back to the Vietnam war, Heaney and Rojas argue that this alliance was used as a means of establishing partisan control rather than on making substantial changes to foreign policy. Once Democratic control was assumed following the election of President Obama, the alignment with the anti-war movement began to fade. This supports their conclusion, which argues that when a social movement conflicts with political identity, individuals would be more likely to side with their political party (2015).

Despite the mixed results of this debate, research on partisanship's tenuous effect on policymaking has continued, especially for local and state politics. In a study done by Erikson, Wright and McIver, the authors argued that party control of a state legislature does not serve as a good predictor for state policy; while it would be easy to assume that this is due to electoral politics being insignificant, the authors contest that party positions will respond to broader state opinion, state elections can reward or punish their state parties based on this responsiveness, and

that Republican and Democratic legislators will moderate their policy positions as a result (1989). Additionally, research that explored the impact of gubernatorial partisan influences on their policy outcomes found that of the thirty-two measures related to policy outcome and social welfare, twenty-six showed no statistical impact on outcomes, arguing that governors largely behave in a non-ideological way (Leigh, 2008).

Partisanship and the Medicaid Expansion

Considering the mixed results discussed above, the role and effect of partisanship on policymaking – on the federal and state level – has become increasingly relevant in relation to the Affordable Care Act. In a study reminiscent of Fiorina and Adams, Henderson and Hillygus sought to evaluate whether the partisan divide concerning the Affordable Care Act in Washington could be found among the public. Evaluating health care attitudes between 2008 and 2010, the authors found that "partisan attachment and self-interest strongly predicted change in health care attitudes, with Republicans growing more opposed to universal health insurance… and those personally worried about medical expenses less likely to abandon support" (2011). Yet research by Tesler has argued that the growth of political polarization from the public towards health care policy came from polarizing opinions about racial attitudes and race. Comparing a 2009 survey with two decades of cross-sectional surveys, Tesler found that racial attitudes had a significantly larger impact on health care opinions than purely partisan differences. When hypothetical health care proposals were attributed to President Obama, opinions become more racialized than when these proposals were attributed to former President Clinton (2012). Though the discussion of racial politics and its effect on the Affordable Care Act will be discussed in

later sections, the intermingled results of this study illustrate the effects of partisanship with social identity.

As discussed in Chapter 1, the perception of the Medicaid expansion has evolved as the implementation and effects have begun to unfold. As of March 2018, 54 percent of the public held a favorable view of the ACA, "the highest level of favorability measured in over 80 Kaiser Health Tracking Polls since 2010" (Kirzinger, Wu and Brodie, 2018). For the Medicaid expansion, this positive perception holds steady, with 74 percent overall holding favorable views of Medicaid. Despite these increasingly positive public views, calls to 'repeal and replace' the ACA has become a campaign promise for the Republican party (Scott, 2017). For two years preceding his election, President Donald Trump promised a total repeal and replacement of the ACA which would include insurance for everybody, no one losing coverage, nobody being worse off financially, that artificial state lines would be erased, that there would be no cuts to Medicaid, and that everybody would be taken care of, amongst other promises (Jackson, 2017 and Conway, 2017).

However, President Trump's initial efforts to uphold this promise have faltered. In March of 2017, President Trump and Speaker Paul Ryan proposed the American Health Care Act (AHCA). However, the AHCA encountered numerous obstacles eventually leading to it ultimately being pulled from the vote, not solely due to partisan obstructionism but rather because of in-fighting within the Republican party (Cornwell and Abutaleb, 2017). Although Democrats and major health care providers opposed the passage of the bill, a primary obstacle came from far-right conservatives in the House Freedom Caucus who rejected the compromises put forth (DeBonis, O'Keefe, and Costa, 2017). Moderate Republicans also disagreed with the

plan, arguing that the AHCA would remove health insurance for many of their constituents, many of which had taken to confronting them in town-hall meetings (Frizell, 2017). Though Democrats remained firmly opposed to the bill, it was the hardline stance taken by fellow Republicans that led Speaker Ryan to pull the bill and profess "Obamacare is the law of the land and will remain so for the foreseeable future" (Conway, 2017).

Later efforts to 'repeal and replace' the ACA were met with similar results. In June 2017, Republican leadership released the Better Care Reconciliation Act (BRCA). Reminiscent of the AHCA, the BRCA also included provisions that would fundamentally change Medicaid, including setting a limit to federal funding through a per capita cap or block grant (Rudowitz, Antonisse, and Musumeci, 2017). Like the AHCA before it, Democrats and major health care providers were opposed to the passage of the bill (Hartmann, 2017), arguing that the bill would not only substantially undermine the effectiveness of Medicaid, but it would hinder mental health care treatment and that the bill itself was "heartless" (Kim and Schor, 2017; APA, 2017; Stafford, 2017). Along with this opposition, several Republican Senators were opposed to the bill for many of the same reasons for their opposition to the AHCA; while some Republican senators argued that they would not sign the bill as it did not fully commit to repealing and replacing the ACA, other Republican Senators such as Senator Heller of Nevada and Senator Portman of Ohio – both from states who had expanded Medicaid – expressed reservations to the cut to Medicaid funding (Bryan, 2017).

Following the passage of a House-measure, the Senate attempted to vote on the repeal bill on July 27th, only for the bill to be voted against by Senators Collins of Maine, Murkowski of Alaska and McCain of Arizona – all in states who had expanded Medicaid (Roubein, 2017).

Following this failure, Senate Majority Leader McConnell – the senior Senator of Kentucky which had also expanded Medicaid – proclaimed that it was "time to move on" and for the Republican party to pursue tax reform in the next year (DeBonis and Phillips, 2017). In the months leading up to and following these failed repeal efforts, there have been several arguments for why the repeal efforts have failed. While some argued that it was a policy problem as the Republican party had made significant promises to repeal the ACA but had no consensus on what plan should be used to replace it (Scott, 2017 and Cunningham, 2017), others argued that it was the lack of help and support from President Trump (Kaplan, 2017 and Frum, 2017), and fierce opposition from Democrats and their constituents (Bacon, 2017) that led to the failed attempts. Yet the opposition from Republican Senators – specifically for those whose states had expanded Medicaid both fully and through special provisions – posits an intriguing argument.

Although political identity can be perceived to be of supreme importance and partisanship can be a significant motivating factor for why both political elites and the electorate can act the way they do, the Medicaid expansion has worked remarkably well for the states who have chosen expansion (Antonisse et al., 2018). Additionally, despite its implementation by a Democratic President and Congress, the legislation itself can be considered an extension of moderately conservative policies (Garthwaite, 2017; Kleinke, 2012; Taylor, 2015) though some have argued against this premise (Butler, 2012). Nevertheless, although the 'repeal and replace' party line has been a hallmark of recent political campaigns (Martin, 2017; Glass, 2017; Johnson, 2017), it could be argued that the loss of coverage that constituents would feel would be too severe for some politicians to accept (Scott and Kliff, 2017). In an article published by *Politico*, writer Rachana Pradhan described the fight of Republican governors who expanded Medicaid to

protect the health coverage of their constituents while their party – and President – actively called for the total repeal and replacement of the ACA (2017). Pradhan quoted several governors who opposed the repeal effort, many of whom spoke of the positive benefits the bill had on health outcomes of their constituents. While their determination was a sharp turn away from most of their party, the Republican governors remained adamant that they would not compromise their constituents' health and access to care, demonstrating the fervent passion of these Republican governors to maintain Medicaid expansion – despite intense backlash and critiques by members of their own party.

Yet this separation wasn't universal among Republican leaders in states who had expanded Medicaid. In a scathing editorial published in the *Lexington Herald Leader*, the writers describe the cognitive dissonance present in how Senator Mitch McConnell dissociated Kynect – insurance exchanges made possible by the ACA – and expansion of Medicaid eligibility in Kentucky with President Obama and the ACA (2014). Although Senator McConnell remained a fierce opponent of the ACA and consistently called for the full and total repeal of the ACA, statements made to the public during his re-election campaign showed a clear dissociation between President Obama and the ACA and Kentucky's own involvement in accepting his policies. Polls conducted in Kentucky during this time illustrated that voters also had difficulty in seeing the clear and direct relationship of President Obama and the ACA with health care access in Kentucky. While it would be an exercise in lunacy to assume that the state of Kentucky's health care policy is somehow unrelated to the President and legislation that made it possible, the editorial argued that if the Senator were incapable of seeing this relationship, the public could not be expected to make it as well. Examining his refusal to connect the two together provides

support for the idea of political partisanship being a motivating factor toward those who opposed the Medicaid expansion while providing an example of the ideological battleground present even among states that expanded Medicaid.

Social Class and Opposition

As described in Dolgin and Dietrich's first conclusion, the role of class and social mobility in American politics has become an increasingly relevant metric for evaluating how the public will perceive potential policy solutions; for many, their perception on socio-political class can be a means of evaluating another's moral worth (2011). In his best-selling memoir *Hillbilly Elegy*, lawyer J.D. Vance discusses at length the struggles and the pride found in his upbringing in the Ohio rust belt. Using "learned helplessness" – the theory based in psychology that contends individuals will suffer from powerlessness that arises from repeated failures (Seligman, 1972) – Vance articulates the cognitive dissonance that can be found in poor, white communities who show a "broken connection between the world we see and the values we preach" (Vance, 2016). While those in his community would praise the importance of family life, hard work, and criticize individuals who abuse the welfare system, some of the same are victims of alcoholism and pursue divorces, quit their jobs because they are "sick of waking up early" and know of – if not they themselves are – experts at gaming the system (Rothman, 2016). In Vance's community – and others like him – the division of people is largely based on their identity through social class and their economic status. Arguing that when their identity is threatened by those who perceive themselves to be "better," namely those who are of a higher economic status or of those perceived to be 'undeserving', their identity with "hillbilly culture" will give them the excuse to shift blame to the government, to society, and to others (Rothman, 2016).

Though many have critiqued Vance's words for its lack of attention to race and institutional, systemic discrimination (Rader, 2017; Catte, 2017; Lewis, 2017), other research supports Vance's thoughts and ideas. In her years-long ethnographic study of the attitudes and views of rural Wisconsin, Dr. Katherine J. Cramer argued that a possible explanation for the disconnect between policies that would benefit these communities and the policies they actually support, goes beyond strictly partisanship, racism, and elitism but rather a theory of 'rural consciousness' which serves as the lens for how they view and perceive the world around them (2016). Cramer further argues that the relationship between an individual's economic interest is directly related to their perception of how the government does – or does not – support them, leading towards the ideology of a 'politics of resentment.' Using rural consciousness as a frame to understand this perception, Cramer argues that framing tactics used by elected officials can transform an argument of policy into an argument against their individual values and ideas, where their resentment bleeds into a miscarriage of distributive justice, regardless of evidence to support the contrary (Cramer, 2016).

These framing tactics – and the intermingled relationship of media, elected officials, and public opinion – have been of long-running interest within the social sciences (Brewer, 2002; Jacobs and Mettler, 2011; Filindra and Kaplan, 2016; Gross, 2008; Knowles, Lowery, and Schaumberg, 2010; Maheswaran and Meyers-Levy, 1990; Bizer and Petty, 2005). Research by Nelson and Oxley explored the idea of framing issues using "value words," linking these political issues towards abstract values (1997) with similar research finding that these framing tactics significantly affected opinion on these issues (Nelson and Oxley, 1999) and can affect how an individual describes the issue (Brewer, 2002). Additionally, Gross found that framing

political issues occurs both on the cognitive and emotional level (2008). As discussed in the previous example of Senator McConnell, the disconnect between policies may be a result of partisanship, opposition based on social class identity, or through the framing tactics by persuasive politicians. Yet the unique struggle of the Medicaid expansion – and its connection to the ACA and President Obama himself – provides another avenue to explore.

Race, Policy and Perceptions

As discussed by both Dietrich and Dolgin (2011) and Lanford and Quadagno (2016), evidence exists that racial animus towards President Obama and its effect on the political and social perception of his policies has had a tangible effect on the perception, relationship and acceptance of his policies. In their 2011 study, Barreto et al. describe the significance of the development and rise of the Tea Party movement– a far right movement that began following President Obama's election (Maxwell, 2016) – as being a representation of out-group social anxiety over social and demographic changes in the United States (2011). In 2014, the Census Bureau estimated that minorities would encompass over 56 percent of the population, effectively ending the role of white individuals as the majority (Wazwaz, 2015). Using this information in their research on group status threat and racial identification, Craig and Richeson found that white individuals presented with this information – regardless of political affiliation – were more likely to endorse more conservative ideals concerning racially inclusionary policies (2014). Comparable results found by Outten et al. (2011) suggested that when individuals are confronted with information concerning the rise of one group, a zero-sum competition begins and the assumption that 'their' group will fall increases the level of anxiety and negative racial attitudes (Resnick, 2017). This manifestation of group and social anxiety can thus prompt individuals,

who would not otherwise be considered or consider themselves as holding racially negative beliefs, to advocate for and support these types of policies and ideals (Barreto et al. 2016).

This anxiety – although typically manifested throughout outwardly racist ideals – can also develop through implicit racial biases, also known as "symbolic racism." Sometimes linked to other theories of modern racism such as 'unconscious racism' (Blanton and Jaccard, 2008), 'racial ambivalence' (Katz, 1988) and 'subtle racism' (Pettigrew and Meertens, 1995), Sears and Henry distinguish symbolic racism from these theories and from what they refer to as 'old-fashioned' racism, by arguing that it is predicated on an anti-minority, particularly anti-Black, sentiment and aligned with politically conservative ideals (2003). Rather than being just a new method of reframing the argument concerning racism, Sears and Henry argue that symbolic racism is distinct as it is racial prejudice coalesced into a specific political belief system upholding four specific ideals: "a) blacks no longer face much prejudice or discrimination, b) black's failure to progress results from their unwillingness to work hard enough, c) blacks are demanding too much too fast, and d) blacks have gotten more than they deserve.". This distinction is further supported through research from Tarman and Sears, who found that individuals can hold both 'symbolic' and 'old-fashioned' racist ideals (2005).

However, critics of the symbolic racism theory argue that the idea of symbolic racism as a separate metric conflates racial resentment with individual's attitudes and perception toward racial policies (Carmines, Sniderman, and Easter 2011) or explains factors more attributable to social dominance theory (Sidanius, Deveraux and Pratto 2001). Others have argued that the separation of symbolic racism from old-fashioned racism not only blurs the distinction between racist and nonracist sources of white opposition to policies that assist minorities, but also

politicizes the concept of racism in social science research (Sniderman and Tetlock 1986; Roth 1989). Despite these critiques, the theory of symbolic racism has continued to develop, with a 2005 study summarizing the effects of symbolic racism as remaining constant, substantively meaningful, and statistically consistent as a belief system (Sears and Henry, 2003).

Nevertheless, there is evidence to suggest that the association of racial resentment and opposition towards to the ACA cannot solely be explained through ideological preference. Evaluating anti-black prejudice from the beginning of the 2008 election, Knowles, Lowery, and Schaumberg found that when controlling for explicit prejudice, the association between implicit prejudice and opposition toward health care reform increased when plans were attributed towards President Obama compared to President Clinton (2010). Similarly, Henderson and Hillgyus saw that while partisanship and self-interest was a strong predictor for views concerning health care reform, racial resentment increased in the two years following Obama's election (2011). Another study (Maxwell and Shields 2014) saw that when health care legislation was framed as being 'President Obama's healthcare,' there was a magnitude of difference in negative responses to questions concerning health care overall. While these studies do not directly correlate opposition to the ACA as being a direct result of racial resentment, there suggests a relationship between negative perceptions of Obama and his policies, not as a political opponent, but as a black man.

As the development of the Tea Party suggests, far-right opponents of Obama were based not just in political ideology, but in unequivocal racism (Waldman 2014). Conservative commentators such as Rush Limbaugh, Bill O'Reilly and Glenn Beck have argued against the ACA, interpreting it to be a form of redistributive justice for "historical grievances" such as slavery (Waldman 2014). Although Democrats in Congress repeatedly argued that opposition

toward Obama was predicated on the issue of his race, not policy (Gordon and Douglas 2014; CNN Staff 2014; Kaczynski 2014), many Republicans, Democrats, and the Obama Administration itself denied these claims (Robinson, 2009 and Isenstadt, 2009). As the research by Lanford and Quadagno suggested, racial resentment as a means of understanding opposition towards the ACA suggests a mechanism for further understanding the specific situation, the values present, and the fierce opposition to Republican governors that decided to expand Medicaid.

Considering the previous research, the following chapter will explore the purpose of the research and evaluate whether the language and rhetoric used by four Republican governors that fully expanded Medicaid held similar themes to the research discussed above.

CHAPTER 3

RESEARCH METHODS AND DATA COLLECTION

Research Methods

The purpose of this research is to explore the rhetoric and descriptive terminology used by four Republican governors who chose to fully expand Medicaid. The overarching goal and question of this exploratory research is: what were the key themes used to describe why these four Republican governors chose to expand Medicaid? Using qualitative content analysis as a tool for a qualitative descriptive case study, the following chapter will explore the key phrases and themes used by these governors to explain their decision to their constituents.

This study will use the qualitative Case Study method (Creswell, 2007) to gather rich, nuanced details of the various factors leading governors to support the Medicaid expansion. This study addresses the need for detailed and nuanced case studies that will allow a deeper or fuller understanding of factors in each of the state's leading to support for Medicaid expansion as described in the literature review. This study will also aid in an improved understanding of similarities and differences among these factors and will increase understanding the different state outcomes. As discussed by Schavelson and Towne (2002), case studies can be a complement to statistical or quantitative experiments; using the statistical analysis conducted by research by Dolgin and Dietrich (2011), Flagg (2016), Lanford and Quadagno (2016) and others, this case study can help provide thick, contextual descriptions and information to understanding the environments, problems, and factors that could have contributed to the Republican governors decision making (Yin, 2009). As described by Creswell, the theories and ideas presented can help elucidate the social process of people, furthering the understanding of the data collected

(2007). This research also will use qualitative Content Analysis with the primary unit of analysis being historical documents such as newspaper coverage and editorials, political speeches, press releases, public memos and other public resources that describe the speech or language used by governors to describe the Medicaid expansion to the public. According to Patton and Appelbaum, case studies provide the "opportunity for a holistic view of a process (2003) while qualitative content analysis "comprises a searching-out of underlying themes in the materials being analyzed (Bryman, 2004). Thus, combining these methodological approaches not only improves the holistic, thick description of the realities the governors faced along with the terminology used to describe it (Jick, 1979), but provides a "multi-dimensional perspective that may be used to create a shared view of the situation being studied (Remenyi et al., 2002). As argued by Kohlbacher, qualitative content analysis fits perfectly with the ideology of case study research: "helping to understand complex social phenomena" (2006).

This research will build upon the work completed by Dolgin and Dietrich (2011), Lanford and Quadango (2016) and Flagg (2016). The key factors discovered by Dolgin and Dietrich (2011) and Lanford and Quadagno (2016) – political partisanship, social class opposition, and racial resentment – served as the three key themes that were analyzed further through qualitative content analysis. Lanford and Quadagno's (2016) research provided strong statistical support for the selection of these themes. Similarly, the results of the mixed-method case study conducted by Flagg illustrated the importance of interpreting the meanings behind the decision to expand Medicaid. Through content analysis of the interviews conducted, Flagg was able to show how context surrounding the governors' political pressures, personal beliefs, and

justifications through their political speech illustrated a more complete picture of how their decision-making came about compared to statistical analysis.

The use of content analysis of political speech is prominent in the literature. Finding causality between political speech and political action would be impractical for this study, nor is that its intended purpose. However, using content analysis towards understanding and interpreting political speech has been commonly used in the social sciences (Tetlock, 1981; Neuendorf, 2002; Krippendorf, 2003). Using speeches as a proxy for political action, Khudoliy has described political speech as a means used by political actors to express the "goals, values, and socio-political strategy of one political group, and [seeking] to convey and impose information on electors and political opponents" (2016). Similarly, Schimmel explored the framing tactics used by Democratic presidents to reshape the ideology of governmental intervention in health care reform. Using rhetoric analysis, Schimmel also explored Democratic responses to Republican discourse and opposition to universal health coverage, giving particular attention to the "coded" phrasing of these groups in describing governmental intervention (2016). Republican ideology rests largely on the ideal of "limited government," a phrase that Schimmel argues is not used solely as a descriptor of actual size, but also a means of "referring to a range of implicit assumptions about which social issues and sectors of the population deserve the attention and resources of the government" (Schimmel, 2016). These analyses serve as the framework this research will follow.

As described by Schreier, qualitative content analysis is guided by and characterized by three key features: the reduction of data, its systematic nature, and its flexibility (2013). While similar to quantitative content analysis, qualitative content analysis is used to provide more

contextual, nuanced descriptions of the study focus. As a result, the coding frame – a conceptual scheme to help identify, sort, and translate raw data (Benaquisto, 2008) – is partly data-driven. Following the data collection, the deductive coding scheme as described by Elo and Kyngas was selected. As described in Figure 4, the deductive coding analyzes speech, literature, phrases, etc. through one broad theme, sub-dividing into main generic categories, and further dividing into specific sub-categories.

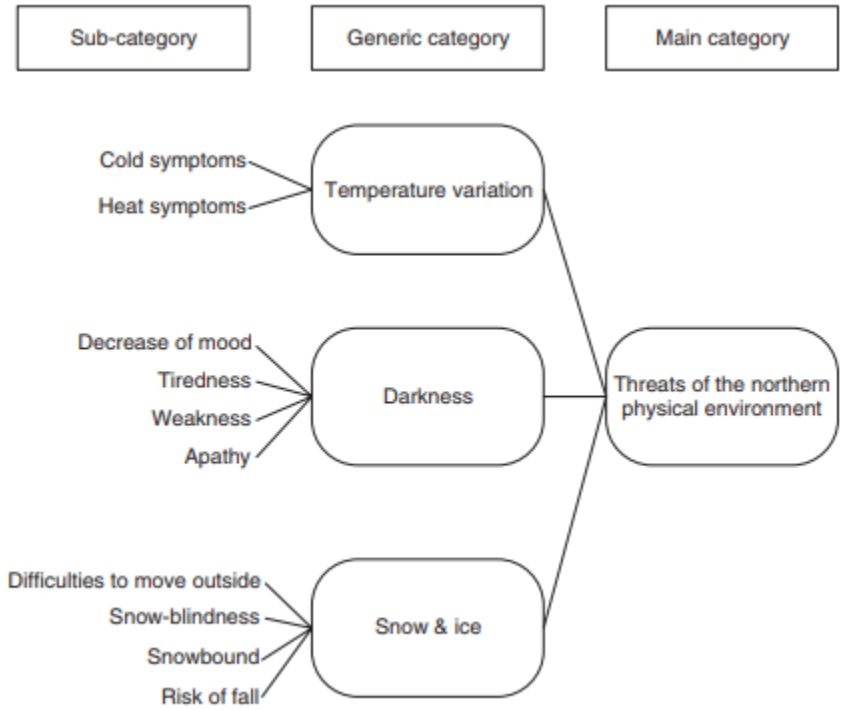

Figure 4. Example of the Abstraction Process for Deductive Qualitative Content Analysis as described by Elo and Kyngas, 2007.

Though this analysis is not meant to be an exhaustive description of the interpretations of the four governor's speeches, it is completed with the intent of providing a thick description of their phrasing with a discussion of how these themes may be used to understand the decision-making process of the governors through both manifest and latent analysis. While manifest

analysis looks solely at the words themselves and the visible, obvious conclusions of a text (Bengtsson, 2016), latent analysis goes beyond the obvious and attempts to interpret the meaning of the text (Berg, 2008). This mixed-method content analysis has been chosen as it will provide a more complete look into what policymakers said about the Medicaid expansion, while also considering the contextual environment, actors, and social factors that influenced what policymakers said and how they went about saying what they said (Neuendorf, 2002).

Data Collection

The governors chosen for this study were Brian Sandoval (Nevada), Susana Martinez (New Mexico), Jack Dalrymple (North Dakota), and John Kasich (Ohio). States chosen for this study were based on the following criteria: there was a Republican Governor in office following the 2012 NFIB v. Sebelius decision and these Republican governors decided to expand Medicaid fully. Though both Alaska and Kentucky passed a full expansion of Medicaid, the governors at the time were Independent and Democratic respectively and have thus been excluded. As of January 2019, 37 states have chosen to expand Medicaid. For this research, the study period was selected from June 2012 to December 2015. This period was chosen due to availability of data for the four governors chosen, its immediate proximity to the Supreme Court decision, and its distance from the 2016 election. Although an exploration of the rhetoric and justification given by these governors on their decision to expand during the 2016 election – and in the years following would be of interest for future research, the lack of thick, contextual data for each of the governors described in this study allowed for this year to be eliminated.

The data – which includes newspaper coverage, excerpts of local speeches, State of the State addresses, and other commentary or op-eds published by the governors themselves – was

collected through the database NexisUni. The collection period was completed from May 2018 until December 2018 with analysis being completed from December 2018 to January 2019. Selection of newspaper coverage through NexisUni was based on the following search terms: the state, the full name of the governor, Medicaid expansion, and the selected time frame. This process was repeated for each month of each year throughout the selected study period. Further selection of newspaper coverage was selected based on its inclusion of direct quotes from the governor in question, with duplicates being removed as needed. Though it is possible that there were data sources that were eliminated through this process, the purpose of this research is not meant to be a comprehensive, causal explanation for why the governors chose to expand Medicaid but rather an intensive exploration of the four governor's description in their own words. As described by Gentles et al., this form of qualitative content analysis is less of a systematic review, but rather a "snapshot" of their perception within their natural setting (2015). As with all research, there are several limitations that may inhibit the full evaluation of the data. These limitations will be discussed further in Chapter 6. The following chapter describes the coding themes uncovered with an analysis of how these coded themes emerged from the data itself.

CHAPTER 4

ANALYSIS OF GOVERNORS DECISION TO EXPAND MEDICAID

As discussed in the literature review in Chapter 3, previous research indicated that there were several themes that arose when determining the gubernatorial decisions concerning the Medicaid expansion. These themes – partisanship's effect on state level decision making, anxiety among the social classes, and negative racial rhetoric – were used as thematic guidance markers when evaluating the data. However, the research question required that the research must also be applied with the assumption that the data – and the results that arose from that data – must determine what major themes and rhetoric were used based on what became available from the data itself. This process – both deductive and inductive – allowed for a more flexible interpretation of the data and illustrates the complexity of evaluating these issues from a qualitative perspective.

The focus and intent of this research was developed to explore the key themes, factors, and indicators that each of the four governors faced following the 2012 Supreme Court decision concerning the Medicaid expansion. Through qualitative content analysis, the key themes that the governors used to articulate their decision-making process can aid in interpreting what explanations the governors used to describe their decisions, despite perceived political and social obstacles. Though a causal relationship between what factors may have contributed to their decision making and the explanations they gave to describe their decision cannot be made, it is not its purpose. Rather, using qualitative content analysis identifies prevailing themes and patterns found within forms of communication (Leedy and Ormrod, 2001).

In addition to the results of the qualitative content analysis, the examination of the themes found in political messages cannot be accurately depicted without further contextual evidence to the environment in which they were made. As described in Chapter 3, the political speech of political actors can be a proxy for understanding what their beliefs may be concerning an issue (Khudoliy, 2016). However, the role of governors and the impact of their decision making cannot accurately be observed without considering the specific, contextual environment that they are in. Though governors can have considerable latitude in enforcing their own political and policy visions for the state (Rosenthal, 2013), they are also subject to a variety of mitigating factors that their national counterparts may not face on a similar level. While governors may also be subject to political and partisan influence (Flagg, 2016), governors are arguably confronted with the necessity of being pragmatic in their decisions as they work with their state governing body and appeal to their electorate (Rosenthal, 2013). In a study on gubernatorial decision-making on Senate appointments, Cooper, Knotts, and Ragusa found that governors were more likely to make their decision based more on the ideological positions of their electorate rather than by their own political beliefs (2016). Thus, when analyzing the themes and messages that the four governors used to describe their decision-making, a description of the social and political climate of the time further contextualizes the environment that these messages were framed. The following analysis will evaluate the words of the governors themselves, followed with a thick-contextual description of the political and social environment that each of the governors faced during the selected study period.

Based on the results of the qualitative content analysis, three major themes emerged from data that can be described as follows: Advocacy for the Disadvantaged, Fiscal Responsibility, and Appeal to Rationality. A count of these for these three themes can be found in Table 1.

Table 1. Descriptive Count of References for 3 Major Themes

Governor Name	Advocacy for the Disadvantaged	Fiscal Responsibility	Appeal to Rationality
Sandoval	4	10	3
Martinez	11	6	4
Dalrymple	1	0	1
Kasich	21	13	4
Total	37	29	12

The themes were derived from the text itself, grouping according to the phrasing and language used by the governors. As shown in the process of Elo and Kyngas in Figure 3., qualitative content analysis is a systematic process that starts wide until gradually reducing (2007); by continuously reducing the data, the most prevailing themes and messages within the data become more relevant (Schreier, 2013). Thus, the three themes were determined after a systematic review of the collected content collected. The count of material collected via NexisUni varied for each of the governors listed but the process remained the same.

Each article collected was reviewed to determine when and where direct quotes from the governors were found and were then transcribed into a separate word document. This process was completed for each article collected, organized by each year and for each governor. This process was then repeated a second time to ensure that any quotes or messages were not missed. Once quotes and key details were transcribed, the coding process began with each phrasing or comment labeled using the key words the governors used themselves. For example, Martinez

referred to using the Medicaid expansion as "making sense" with Sandoval, Dalrymple, and Kasich all using similar phrasing. For the first step of the coding process, these were categorized broadly using the terminology the governors themselves used. Once completed, this coding frame was used again as a means of reducing the data and to categorize the themes as a way of interpreting their meaning (Mayring, 2003). This process was again repeated for each governor in each year collected and repeated a second time to ensure trustworthiness (Elo et al., 2014).

Following categorization, the themes were further reduced and organized in relation to each other. For example, Kasich repeatedly used phrasing that invoked the use of "compassion" while also specifically referencing the expansion as being useful for "the needy". These themes were combined and resulted in one of the final three themes: "Advocacy for the Disadvantaged". The resulting themes were then further consolidated; though six overarching themes were developed with this method, only the three discussed in Table 1 were included in this analysis. The purpose of this exclusion was based not only on purely numeral basis – as the three included held the highest counts – but on the amount of comparison and similarity with the three governors. For example, while Kasich repeatedly made references to his ideological interpretation of the Republican party as being an explanation for his decision-making, this same reference wasn't found nearly to the same extent for Sandoval, Martinez, and Dalrymple, if at all. As part of the goal of this research is to illustrate the similarities and differences among the four governors, these were eliminated. A further discussion of these themes and their implications for future research can be found in Chapter 6.

Though the resulting themes and count references gives numeric credence to the themes that emerged, a count in and of itself is insufficient in exploring not only how these themes came

to be, but for how the governors described their rationale contextually. One of the prevailing purposes of qualitative content analysis is to derive contextual meaning from the analysis as context is "central to the interpretation and analysis of the material" (Kohlbacher, 2006). As discussed by Kracauer, counting patterns is not merely enough to analyze a text, but rather providing context allows for an understanding of "multiple connotations" (1952).

Thus, the following narrative analysis will illustrate the themes of the governors in both chronological and alphabetical order. This determination was chosen as a means of presenting the data without preference, as well as providing a fuller, contextual picture of the mood and evolution of the governor's explanations as time progressed.

Narrative Analysis of the Four Governors

NEVADA

Brian Sandoval was the first Republican governor to expand Medicaid (Young, 2012). However, Sandoval – a Hispanic first-term governor (Nevarez, 2014) – was initially hesitant in pursuing the expansion for Medicaid. In the months following the Supreme Court ruling, Sandoval commented against expansion as he believed it would place too significant a burden on individuals, businesses, and the states themselves (Whaley, 2012). However, by December of that year, Sandoval reasoned that despite his dislike of the Affordable Care Act and its burden on both businesses and citizens, "*…the law has been upheld by the Supreme Court. As such, I am forced to accept it as today's reality and I have decided to expand Medicaid coverage*" (Tribune News Service, 2012). Later comments reflected this phrasing, with Sandoval articulating that despite his personal opposition to the ACA (Haberkorn, 2013), expanding Medicaid was not only the fiscally responsible thing to do (Matthews, 2012), but was imperative as a way of advocating

for those who were at a disadvantage. In a comment to a newspaper editorial board, "*I couldn't sit here and defend to any of you $16 million that just went away because of 'principle'*" (Babington, 2013).

At the time of his announcement, state officials expected that implementing the Medicaid expansion would increase the coverage of an additional 78,000 low-income Nevadans – an increase from the already 70,000 who were previously eligible (Damon, 2012). Though expanding would cost the state $67 million, Sandoval's office made it clear that this would be a massive leverage of federal dollars for the state of Nevada. According to state officials, opting out of expanding Medicaid would only have increased the burden on the general fund for Nevada; by choosing to expand Medicaid, Sandoval's office argued that they were avoiding future costs (Damon, 2012).

In his 2013 State of the State Speech, Sandoval was forthright about his decision to expand Medicaid arguing that because of his decision, the uninsured rate for the state would not only decrease, but the financial stability of the state would increase exponentially; Sandoval touted that the increase in spending would allow for current resources to be redirected towards mental health programs, would create thousands of jobs in the health care sector, and would increase millions into the state economy (Sandoval, 2013). As predicted, the uninsured rate for Nevadans fell nearly 40 percent between 2013 to 2015 (Barnett and Vornovitsky, 2016), with Medicaid enrollment growing exponentially even beyond the states projections.

According to the Health and Human Services Director at the time, applications for Medicaid had historically processed 12,000 each month. Following Sandoval's decision to expand, the number of enrollees rose to 38,000 in December 2013 (Whaley, 2014). Prior to

expansion, Nevada had one of the highest uninsured rates in the nation; in 2012, 22.2 percent of the population had no health insurance, with 16.6 percent of minors not having coverage which at the time was more than double the national rate (Hess, Sauter, and Frohlich, 2013). Following expansion, the initial rise of enrollees exploded; according to state numbers, the number of Medicaid enrollees in Nevada grew from 330,000 in September 2013 to 601,000 in August 2014, an almost 82 percent increase (Galewitz, 2014). Despite this growth, the state faced some issues in providing adequate care, with many providers feeling overwhelmed with the increased number of patients (Galewitz, 2014). Nevertheless, Sandoval's push for advocating for the needy in his state while remaining cost efficient has appeared to pay off. According to report in 2017 by the Kaiser Family Foundation, expanding Medicaid reduced longstanding disparities that many in the Hispanic population faced, with the uninsured rate for nonelderly Hispanics falling from 34 percent to 19 percent (2017). As a means of exploring explanatory factors for Sandoval's decision, the benefits of expanding Medicaid not only benefited those who were the neediest but provided the most gains to a population that the Republican party was interested in courting.

Considered to be an up-and-coming star of the Republican party (Wilson, 2013), Sandoval is now considered to have taken a moderate approach to governing and worked with his Democratic legislature on bipartisan pieces of legislation concerning state taxes and education, to the chagrin of the more conservative members of his legislative body (Damon, 2013, Roerink, 2015 and Jacobson, 2015). Sandoval stands out among the four governors as being the first Republican governor who chose to expand Medicaid (Young, 2013b). Though this was a sharp departure from the Republican party's stance towards the Affordable Care Act (Parsons, 2012), Sandoval did not face nearly as much backlash as anticipated (Haberkorn,

2013). In April 2012, Sandoval was rated as one of the 10 most popular governors, with a 67 percent and 63 percent approval rating from Rasmussen and Public Opinion strategies, respectively (Blake, 2012). These numbers only continued to rise following his decision to expand Medicaid, though some wondered whether this popularity would hold if Sandoval chose to pursue the national spotlight (Wilson, 2013). Sandoval's high approval numbers could be attributed to his personality and presence as previous research has suggested (Ferguson and Barth, 2003), yet seeing his popularity as being the only factor that could have potentially contributed to his explanation for expanding Medicaid would be incomplete.

Nevertheless, Sandoval's immense popularity provides an interesting point of analysis when considering the language he used to describe the Medicaid expansion. Unlike his counterparts, Sandoval's phrasing appeared to be forthright and pragmatic. His comments reflect a reiteration of the practical nature of what the Medicaid expansion would do for the state of Nevada and those with low-income, with a focus on the economic benefits that the state could not – and should not – pass up (Babington, 2013). Despite his broad public support, his popularity among the Republican party in Nevada wavered throughout his tenure. Sandoval seemed dismissive of this, particularly as it related to the seemingly cognitive dissonance of his decision-making (Barabak, 2014). Nevertheless, Sandoval remained popular in Nevada, leaving office with a nearly 60 percent approval rating (Phillips, 2018). In a state that has historically been politically fluid, held record-high uninsured rates, and appeared to have large swaths of an electorate that would benefit the most from an unpopular policy, the phrasing and framing of Medicaid expansion for Nevada appears to fit well with the narrative Sandoval himself gave: *"I'm the one who has to go out in a community, go to a school, a town hall, what have you, and*

be able to look people in the eye and be able to explain why I made a decision one way or another. And my conscience is clear when it comes to that decision [Medicaid]*, that it was the right thing for the people of Nevada*" (Barabak, 2014).

NEW MEXICO

Often compared to Sandoval, Governor Susana Martinez was elected for her first-term in 2010 not only as the first female governor of New Mexico but the first Hispanic female governor in the United States (Strom, 2010). According to political analysts, Martinez, a self-proclaimed former Democrat, was viewed as a symbol for the Republican party (Barr, 2010, Blake, 2012 and Robbins, 2012). Though New Mexico had traditionally trended Republican for both the state legislature and in Presidential elections (Gambino, 2018), the rise of the Hispanic population caused many to wonder if the state would begin to turn towards the Democratic party (Wong, 2014).

Particularly for Martinez, political strategists argued that the vision of Martinez as being a model for the Republican party would not only strengthen the message of "faith, family… [and] small business ownership…" among the Hispanic community but would help enable state Republican politicians to maintain their leadership (Wong, 2014). Some were skeptical of this ideology; though Martinez was ultimately triumphant, she had received only 38 percent of the Latino vote compared to her Democratic opposition who received 61 percent (Martinez-Ebers, 2012). This may have been in part due to her hardline stance towards immigration, which some argued as being hypocritical because of her own background as a child of undocumented immigrants (Mach, 2011 and Urbie, 2012). Nevertheless, the discussion of her popularity among

a voter base that New Mexico was invested in was circumvented by her announcement to expand Medicaid, making her the second Republican governor to do so (Young, 2013).

In a statement read following one of her speeches on the subject, Martinez argued that by listening to advocates for the poor over the past few months, that the decision to expand Medicaid was based on "*what is best for New Mexicans*" (Massey, 2013). In the months following Martinez' initial announcement, expansion became seen as a necessity not only for what it would do for the state and its economy, but for how it would benefit those who are disadvantaged. As described in her 2013 State of the State, Martinez saw that expanding the health care safety net was not only the "*right thing to do*" but increased the efficiency and fiscal effectiveness of the health care system (Martinez, 2013).

By expanding Medicaid, Martinez saw this as "*expanding basic health coverage to… New Mexicans in need"* (Boyd, 2013). This was viewed as a means of increasing that coverage for low-income individuals, but also – like Sandoval – as a way of increasing the amount of revenue into the healthcare system stating, "*We are looking at options for meeting this need in a way that benefits the economies of rural areas in particular*" (Boyd, 2013). Later comments to political commentators and in her 2013 and 2014 State of the State argued that expanding Medicaid was "*the right thing to do*" (Heild, 2014, Martinez, 2013, and Martinez, 2014). Stressing the importance of protecting vulnerable populations such as low-income children, Martinez also claimed that if the federal government were ever to back down from their promise in funding the expansion, New Mexico would withdraw (Martinez, 2013). Following the 2012 election, Martinez remained committed to the decision, articulating that the Medicaid expansion was "*the law of the land"* and that in her view, "*My job is not to play party politics, but to*

implement this law in a way that best serves New Mexico" (Horwath, 2015). Though perceived to be politically unpopular among her Republican counterparts, Martinez faced a unique political and social landscape. Like Sandoval, Martinez worked alongside a Democratic legislature and faced one of the highest uninsured rates in the country (Nather and Millman, 2013).

Following the decision to expand, it was reported that in 2014, 103,000 low-income New Mexicans were enrolled in Medicaid – with nearly 30 percent of the state's population being covered under the expansion (Massey, 2014). A spokesman from the New Mexico Health Department stated that 60,000 of the enrolled Medicaid recipients had previously received limited health care through other state programs, but that the shift allowed them to receive a broader range of medical benefits. By 2016, the number of New Mexicans enrolled into Medicaid increased by 60 percent, standing at 761,033 (Norris, 2018). In 2014, a report in the Wall Street Journal profiled a newly enrolled patient, in which the expanded eligibility allowed him to receive care that had previously been denied to him. At the time, it was reported that New Mexico had the highest proportion of Medicaid recipients of any state, with emergency-room crowding and wait times being some of the worst in the country (Radnofsky, 2014). At the time, practitioners were worried about the influx of the patients and how they would be able to meet the needs of the populace they had – much less the increased enrollees (Heild, 2014).

By 2015, the percentage of uninsured rates in New Mexico dropped 4.1 percentage points. Though this ranked New Mexico as being still among the top 10 in the nation, this percentage drop was among the largest in the United States, with only eight other states seeing drops of more than 4 percentage points (Rayburn, 2015). Furthermore, a report by the Robert Wood Johnson Center for Health Policy found that the overall rate of Hispanics who lacked

health insurance dramatically declined from 23 percent, to 10 percent following the passage of the Affordable Care Act – and was attributed to the expansion of Medicaid (Krasnow, 2015).

In 2016, more than half of all New Mexicans received some form of health insurance from the state government, pushing the uninsured level to historic lows (Krasnow, 2016). Financially, lawmakers stated that there was a lack of data to support the financial and health outcomes of the program. With how the state program was implemented, it was difficult for lawmakers to determine how much the state was paying for each type of service for a patient (Horwath, 2016).

Yet the popularity of Martinez' decision did not bode well for all among the Republican party at the time. The head of the state's Human Services Department Sidone Squier left her four-year 'dream job' position because she was "a very red girl in a blue state" (Horwath, 2015). In this report, public records of an email exchange between Squier and Matt Kennicott, a spokesman for the department, complained that Martinez was 'too afraid' to speak out against the expansion as it would negatively affect her polling and approval numbers (Horwath, 2015). Though the governor's office and Kennicott dismissed the claims as conjecture, Kennicott later claimed that expanding Medicaid was the right decision to make for New Mexicans (Horwath, 2015). This minor scandal illustrated greater issues that Martinez faced throughout her tenure as governor.

In the 2014 midterm election, Martinez won re-election by a 15-point lead, the largest margin of victory for a Republican governor candidate in New Mexico (Monteleone, 2014). However, this win was quickly usurped by plummeting approval ratings, dropping from 69 percent in September 2012 to 42 percent in October 2016 (Boyd, 2018). By the time Martinez

left office, she was ranked as one of the least-popular governors in the nation with a 35 percent approval rating (Moore, 2018). Though some argued this may have been in relation to her political battles and combative style of governance with members of the legislature – particularly those within her own party (Moore, 2018 and Boyd and McKay, 2018) – other analysts have argued that this may have been a result of a stagnant economy and rising unemployment rate (Oxford, 2018). Nevertheless, Martinez' decision to expand Medicaid has been considered a bright spot among supporters – both financially and practically – for the health of New Mexicans, particularly for those among the most disadvantaged (Oxford, 2018). Though the legacy of Martinez is better left speculated on by gubernatorial historians, the persistence of Martinez in believing that the Medicaid expansion was "*the right thing*" for New Mexicans illustrates an interesting portrait of a passionate, committed governor.

NORTH DAKOTA

Jack Dalrymple served as Lt. Governor for the state of North Dakota for almost ten years, succeeding to the governorship after the former Governor had resigned for an ultimately successful Senate run (Beitsch, 2010). With 63 percent of the vote, Dalrymple easily won the 2012 midterm election to serve a full term (Belson, 2012) and unlike the other governors listed, was not subject to the same term limits (NGA, 2015). Additionally, Dalrymple's popularity was consistent, standing in the mid to high 60's throughout his term (Cohen, 2013 and Wilson, 2015). Despite this, Dalrymple chose not to run for reelection in 2016 citing personal reasons (Nowatzki, 2015) and as such, presents a unique case in comparison to the rest of the governors in this study. Additionally, unlike Sandoval, Martinez, and Kasich, Dalrymple did not appear to be constrained by a politically turbulent legislature as both the state houses and senate were

solidly Republican (Rupp, 2015). Furthermore, while some have speculated that Republican governors who chose to expand Medicaid did so more out of necessity for their populace rather than any sort of ideological or personal conviction (Jacobson, 2015), North Dakota doesn't cleanly fit into that narrative; in 2013, North Dakota was considered to be in the mid-range for uninsured rate rankings among states at 10.4 percent compared to Nevada and New Mexico which were at 20.7 percent and 18.6 percent respectively (Smith and Medalia, 2015). Thus, the possible explanatory mechanisms that Sandoval and Martinez – or even Kasich – may have faced, are absent in the case of North Dakota's Dalrymple. Indeed, unlike the three other governors within this study, Dalrymple had the least quotes attributed to him – with much of the discussion being shaped by the North Dakota state legislature (Smith, 2013 and Smith, 2013b).

In the few statements made to the press, Dalrymple seemed less vocally opposed to the Medicaid expansion stating, *"…we wouldn't stand in the way of our people getting more Medicaid benefits in North Dakota"* (Wetzel, 2012). Though he disagreed with the ACA health care plan and market exchanges as being a good policy for the people of North Dakota following the 2012 Supreme Court ruling, he gave no mention of Medicaid itself (Young, 2013). If anything, he seemed amenable to making the ACA successful stating, "*It's not going to help to throw a bunch of roadblocks in front of this thing* [the ACA] *and have it fail. That's not the responsible thing to do"* (Norris, 2018b). By January of 2013, Dalrymple shared similar language with Martinez in describing his decision to expand Medicaid. Stating that "*we try to leave the politics out in the hallway when we make these decisions"*, Dalrymple used the argument that Kasich would eventually run with; "*it comes down to are you going to allow your*

people to have additional Medicaid money that comes at no cost to us, or aren't you? We're thinking yes, we should" (Young, 2013).

Though legislature had heavily debated the measure, both chambers passed the decision to expand Medicaid with a strong majority; Medicaid expansion passed both the Senate and the House at 55-13 and 57-36, respectively (Burnes, 2013). Though the legislators argued that they were reluctant in passing the bill, going so far as to say they were "holding their nose" in voting for its passage (Burnes, 2013), Dalrymple appeared to be favorable to eventually signing the provision (MacPherson, 2013). Though there are few comments or direct quotes to evaluate how Dalrymple came to articulate his decision making, there are other possibilities that could be explored. Though not about the expansion itself, in a 2013 profile by *The New York Times* on rural hospitals in North Dakota, Dalrymple was indicated as being concerned in increasing the funding of these hospitals as the patients in these areas were in dire need (Eligon, 2013). A 2014 report by the Kaiser Family Foundation also showed the benefits of expanding in North Dakota, indicating that coverage would be extended to potentially 70,000 uninsured North Dakotans, particularly the non-elderly adults with low-income (Kaiser Family Foundation, 2014). However, by 2015 it was reported that 16,300 North Dakotans had enrolled into Medicaid since the 2013 expansion (Sisk, 2015). Though the uninsured rate fell from 10.4 percent to 7.9 percent between 2013 and 2014, the United States Census indicated that there was no continuous statistically significant drop in the uninsured between 2014 and 2015 (Barnett and Vornovitsky, 2016).

Nevertheless, in comparison to the three other governors of this study, Dalrymple remains perplexingly silent. Neither his 2013 nor 2015 State of the State address the Medicaid expansion, beyond a cursory mention in stating that payments lost could not be removed as

"*cutting benefits to those in need is not an option*" (Dalrymple, 2013). Though Dalrymple's own views on his decision to expand Medicaid may be sparse, it is the key quotes given that may best articulate how Dalrymple came to describe his decision. Though it would be purely speculative to evaluate what could have contributed to Dalrymple's view when so little information is available, perhaps the lack of data provides a clearer picture in and of itself. Dalrymple, a seasoned veteran of the gubernatorial politics who left following a popular term in office, may have valued pragmatism above politicking or flashy commentary. As discussed by Flagg, governors by their very nature must work more closely with their legislature and take a more practical approach in effective governing (2016). The case of North Dakota's Dalrymple remains an intriguing source of interest – one that perhaps further qualitative study would benefit from.

OHIO

Contrasted with the few and far between comments of Dalrymple, the pragmatic messaging of Sandoval, and the committed albeit shortened comments by Martinez, Governor and eventual Presidential candidate John Kasich provided the most commentary and quotes concerning his decision to expand Medicaid. While some have argued that this was less due to his relationship with the press and more of a result of his planned Presidential run (Stolberg, 2015), the repeated messaging and framing tactics of Kasich provide some of the most richly contextualized and thick descriptions of the entire study. Though Ohio was one of the original states who launched lawsuits against the ACA (Musumeci, 2012), Kasich appeared optimistic at the possibility of expanding Medicaid, arguing that the decision should be motivated by compassion, as the funding received would increase access to care to vulnerable populations (Cooper, 2012 and Marshall, 2012).

Interestingly, Kasich argued for a clear distinction between the ACA and the Medicaid expansion. Though the Medicaid expansion is a direct result of the ACA, Kasich reasoned, "*I don't view this as Obamacare at all. Obamacare, you know, involving an individual mandate I don't support… but this is a different issue. This is about people who are at the lower economic end*" (Sanner, 2013b). Though the ACA marketplace exchanges and individual mandate are not part of the Medicaid expansion, Kasich's dissociation of the Medicaid expansion with the ACA overall was repeated over several interviews, with careful attention given to explain his opposition to the ACA (Sanner, 2013d, Kasich, 2013, Tobias, 2013, Wheaton, 2014, and Fox News, 2017).

Though all four governors mentioned the benefits of the increased Medicaid funding for their people, particularly to the poor or disadvantaged, Kasich was the clearest and most passionate in his defense of seeing the funding as a proxy for helping the disadvantaged. In a speech to the public, Kasich remarked, "*…I can't look at the disabled, I can't look at the poor, I can't look at the mentally ill, I can't look at the addicted and think we ought to ignore them*" (Sanner, 2013c). He repeated these remarks often (Kapur, 2013), arguing that not only was it the right thing to do financially – in op-eds and speeches alike (Kasich, 2013a, Kasich, 2013b, Kapur, 2013, Hutchison, 2013, U.S. Official News, 2013b) – but that it was the morally right thing to do as well (The Lima News, 2013, Coyne, 2013, Suchetka, 2013).

Though Sandoval, Martinez, and Dalrymple all discussed their prioritization of pragmatism over politics in policymaking, Kasich went a step further in justifying his position by likening his decision to expand Medicaid as being similar to previous Republican presidents such as Lincoln and Reagan. "*Abraham Lincoln did what's right to lift human beings, and our*

conservative Republican party must do the same" (The Lima News, 2013). In two separate op-eds, Kasich argued that it was his concern for responsible fiscal policy and the philosophy of Ronald Reagan that helped guide his decision-making concerning the Medicaid expansion. The op-eds are included in their entirety as they provide a contextual description of Kasich's viewpoint and are in the enviable position of them being his own words. In the first, Kasich wrote:

Obamacare is not the path any of us would have chosen, but it's the path we find ourselves on so we better do everything we can to contain its impact until we can take back the White House and fix it. I said no to a state exchange in Ohio for just that reason—to limit Obamacare's impact. I said no to Obamacare's takeover of our state's insurance regulations and no to Obamacare's takeover of our Medicaid eligibility system as well. None of those things were good for Ohio and saying no to them are helping limit Obamacare's impact on my state.

Now I've proposed extending Medicaid health coverage to low-income and working poor Ohioans, in part, to limit further damage from Obamacare . Without this move Obamacare is likely to increase health insurance premiums even higher in Ohio. Worse, it takes $13 billion of Ohioans' federal tax dollars out of our state and gives it to other states—where it will go to work helping to rev up some other state's economy instead of Ohio's. That's what happens if expansion doesn't happen in Ohio.

Whenever federal resources are being distributed to the states—and there's nothing we at the state level can do to prevent that spending—then Ohioans shouldn't be robbed of their fair share . Ohioans earned that money, it's theirs, and they deserve it just like citizens of every other state. Though it admittedly doesn't support expansion, the National Review gets this point and writes, "fiscally conservative governors should not be expected to decline benefits while their constituents' federal tax dollars continue to fund such benefits in liberal states." I make no apologies for ever standing up for my state and any governor who would is in the wrong job .

When I chaired the U.S. House of Representatives' Budget Committee I led the effort to balance the federal budget for the first time since men walked on the moon. I left Washington in 1999 and the federal budget has never been balanced since. In Ohio, in my first budget as governor, I squashed an $8 billion deficit without a tax increase and cut taxes $800 million. This week I proposed another balanced budget that cuts taxes another $1.4 billion and generates a surplus large enough to automatically give Ohioans an additional $400 million tax cut. I'm a passionate budget hawk and proud of it.

I'm also passionate about bringing Ohio back to life. We've gone from 48th in the country in job creation to 6th—in 24 months—and we've got more progress to make. I'm not about to let Obamacare derail us. I'm going to keep doing whatever I can to limit, reduce, curtail and contain its impact —even if it means having to think outside of the box to do it" (Kasich, 2013a).

Drawing on his personal and professional experience as a fiscal conservative, Kasich remained set in his belief that expanding Medicaid in Ohio was the right thing to do, going so far as to say, "*I am not in any way, shape, or form going to shrink from my firm belief on this*" (Provance, 2013a). Though state legislators were hesitant, Kasich seemed ready to go to battle for it claiming, "*I'll be combative when I have to be combative. But there are times when you just have to be patient and I'm willing to be patient here with our friends in the Legislature*" (Sanner, 2013g). This led to his second op-ed, where he appealed not only to the fiscal responsibility aspect of the decision, but for compassion.

"What would Ronald Reagan do?" That's the litmus test many Americans rightly apply to political decisions nearly a quarter-century after he left office. Given the high regard I have for the former president, it should be no surprise that I've asked myself that question before. It's a question we are asking today in Ohio in response to federal health care reform as we consider a plan to reform and expand Medicaid, the health insurance program for the poor. The issue is a complex one and generates strong opinions on both sides. So far, states have divided about evenly on whether or not to opt in to the expansion, with a handful, like Ohio, still debating which way to go. Leaders in the states that have decided against expanding have often invoked Reagan conservatism as the reason to oppose extending Medicaid health care coverage to more people. After all, doesn't Reagan embody modern conservatism? He cut taxes, cut government red tape and fought the growth of entitlements.

Yes, he did all those things. However, he also expanded Medicaid, not just once but several times. For example, in 1986, President Reagan let states add poor children and pregnant women to Medicaid. And after learning that disabled children could receive Medicaid care only in hospitals and nursing homes, he let states provide them care at home also. Ohio resisted both expansions for a decade but saw powerful results for some of our most vulnerable citizens once we made them. Improving the quality of the care Medicaid provides, and giving taxpayers better value for the money they spend on it, have been priorities for me as governor. We've improved health outcomes through better care coordination and also reduced taxpayer spending by $2 billion.

We followed Ronald Reagan's lead and found ways to provide a better service at a lower cost. First, Reagan was fiscally responsible, but he was also pragmatic and compassionate. That's why I have pushed to move forward with a plan to expand Medicaid while protecting Ohio's economic recovery. Extending health care coverage to 275,000 low-income Ohioans — including 26,000 veterans — builds on what we have done. It spares our hospitals the effects of looming cuts in federal funding for uninsured care, prevents additional projected increases in health insurance costs, and gives low-income workers a hand as they move up and into the workforce.

There are serious, ongoing concerns with federal health care reform, and Ohio has already said no to a state-run health care exchange, federal takeovers of our insurance regulations and the Medicaid eligibility process. Medicaid expansion is consistent with these efforts to preserve state flexibility and limit the economic impact of federal health care changes.

As the debate continues, I urge those who esteem Reagan to consider the principled, big-picture perspective at the core of his decisions. When we consider what Reagan would do, let's also remember what he did do — expand Medicaid" (Kasich, 2013b).

Despite his attempts to appeal to being both fiscally responsible and to being morally compassionate, some critiqued his arguments as little more than political framing; Kasich's passion for expanding Medicaid as a balm for the poor confused political analysts as it seemed to conflict with his previous policy decisions as governor (Kardish, 2014) and for many, it seemed to be nothing more than a strategic move towards the center not only for his 2014 re-election campaign, but as a precursor for his bid to the White House (Gabriel, 2013 and Gomez, 2015). This appeared to be further supported in a profile by *The Washington Post* which argued that Kasich's decision to expand Medicaid made him seen more as a moderate or even a RINO, Republican in Name Only (Zak, 2016). Despite this, Kasich took the criticism with indifference arguing, "*we cannot take health-care coverage from people just for a philosophical reason*" (Zak, 2016).

Unlike his counterparts, Kasich arguably had the most opposition to expanding Medicaid and resorted to what was considered a controversial move by using Ohio's Controlling Board (Higgs, 2013a and Wisniewski, 2013). Created in 1917, the Controlling Board was created to provide legislative oversight of capital and operating expenditures and had approval authority over state fiscal activities (OBM, 2013). Though Kasich was initially coy about his plans to use the Controlling Board (Higgs, 2013a), a spokesperson later announced the decision to use the Controlling Board with the indication that they hoped to continue to work with the Legislators

(Higgs, 2013b). In a 5-2 vote, the Controlling Board voted to expand Medicaid, effectively bypassing the legislature and providing Kasich with the outcome he was looking for. Though a suit was filed against Kasich, (Wisniewski, 2013), Kasich defended his maneuver as being, "*…all within the rules. We're fine*" (Sanner, 2013i).

Like his counterparts, the role in which public opinion may have contributed to Kasich's eventual decision is complex. For some political analysts, Kasich's fervent support for the Medicaid expansion was little more than political calculus towards his eventual bid for the White House (Ball, 2015) or as a means of counteracting his previous hardline conservative policy decisions such as a failed bid to remove bargaining rights from public employees in 2011 (Gabriel, 2013). In her research comparing Kasich and Scott Walker of Wisconsin, Flagg argued this point, stating that the electoral pressure that Kasich faced following his defeat could provide a potential explanatory factor for his persistent support for a Democratic policy (2016). Nevertheless, Kasich's support for Medicaid was met favorably by his electorate. Though his favorability ratings had plummeted to 35 percent after the 2011 debacle (Gabriel, 2013 and Kroll, 2013), by 2015 he held an approval rating of over 60 percent (Kaplan, 2015). Like Sandoval and Martinez before him, Kasich handily won re-election in 2014 with a 31-point difference, the second-largest margin in state history (Mayer, 2014 and Balz, 2014). Though some have argued that this was more in relation to the scandals that imploded the campaign of his Democratic opponent (Mayer, 2014), Kasich continued to maintain positive approval ratings as he left office (Gass, 2015), eventually entering his final year at 52 percent (Bischoff, 2018).

The fervent and consistent advocacy of the Medicaid expansion by Kasich provides a wealth of information to observe, one that arguably could not all be articulated within this

research alone. Kasich's unique place in expanding Medicaid was predicated not only on his relationship with the legislature, the favorability (or lack thereof) he faced among his constituents, or even the admonishment of his party, but also the unique incubator of his upcoming Presidential run. Though this could arguably provide further context into evaluating the strength of his messaging and framing concerning expanding Medicaid, Kasich's forthright support of Medicaid continues to be subject to skepticism considering the nascent possibility of future political aspirations (Balmert, 2018). Nevertheless, Kasich's repeated calls for bipartisanship (Kasich, 2017) and his continued advocacy for the Medicaid expansion (Bradner, 2017, Ingles, 2018, and Kasler, 2018) provide a snapshot of a governor at a unique point in time. While whether one factor may have contributed to this rhetoric greater than another may be subject for debate, the effect that the Medicaid expansion had and its implementation in his home state was indelibly linked to Kasich's sense of politics – in the purest form of the word. As Kasich himself has argued, "*It's time for Republicans and Democrats to end the civil war over health care and fight for all Americans. That's how big and necessary change can happen*" (Kasich, 2017).

COMPARISON OF GOVERNORS

As noted in Table 1., the most prevailing theme discussed among the four governors was a call for advocacy for the disadvantaged. Be it Martinez emphasizing that expanding Medicaid would help New Mexicans in need (Boyd, 2013), Dalrymple arguing that politics shouldn't mean keeping additional Medicaid money out of the hands who need it (Young, 2013b), or Sandoval arguing that expanding Medicaid would decrease the number of uninsured in Nevada (Cheney and Hohmann, 2014), all four of the governors framed their discussion around the Medicaid

expansion towards those in their state who would benefit from it the most. Of the four, Kasich was the clearest proponent for this, going so far as to appear on talk shows and penning op-eds in defense of Medicaid (Kasich, 2013a and Kasich, 2013b).

In the months leading up to the 2014 midterms, some wondered if the governors' decision to expand Medicaid would harm their chances of being re-elected. (Scott, Blendon, and Summers, 2014). However, all four governors were listed as being some of the most popular in the country, with Martinez and Kasich being specifically listed for their decision to expand Medicaid (Sullivan and Blake, 2014). Kasich's decision to override the Republican legislature by using the Controlling Board committee was seen as a drastic decision by some (Balmer, 2017), yet commentators suggested that political motivations may have superseded religious ones. Though Kasich was clear that his religious faith strongly motivated his desire to expand Medicaid (Bischoff, 2013), political commentators argued that Ohio's political status as a swing state – with President Obama carrying Ohio in the 2008 and 2012 elections – may have provided stronger motivation to push the expansion forward (Blitzer et al., 2013). Evaluating whether their policy stances mattered for their re-election campaign, neuroscientist Dr. Sam Wang found that in states where governors chose to buck their party's stance (specifically Ohio and New Mexico), their advantage of winning their re-election races were on average 8.5 percentage points better (2014). Though attributing this percentage strictly because of their decision to uphold the health care law would be incomplete, Wang argued that Medicaid expansion acceptance could be a "proxy variable" that could be indicative of other issues (Wang, 2014).

The purpose of this research was to explore the rhetoric and language used by the four governors in their decision to expand Medicaid by building upon previous research into this

topic. Based on the literature review, three prevailing themes – political partisanship, social class opposition, and racial resentment – emerged and were intended to be used as 'markers' for the data analysis. Relating these original themes with the eventual themes that emerged lead to interesting comparisons that will be discussed as follows.

One of the prevailing themes and explanatory factors for how and why governors chose to expand Medicaid was based on the political party they identified with and the partisanship opposition because of it (Flagg, 2016, Barrilleaux and Rainey, 2014, and Lanford and Quadagno, 2016). Though each of the governors appeared to recognize partisan opposition, they all made "appeals to rationality"; whether through articulating that it was a "common sense" policy or that it would be good for the people of their states, each of the governors argued in favor of Medicaid with the recognition that partisanship opposition to the law was strong. Interestingly, though Dalrymple was the one governor to whom the least number of quotes could be attributed to, his statement about "*we try to leave the politics out in the hallway when we make these decisions*" best illustrates this flip on what was such a predicting factor for governors to choose to expand Medicaid. While each of the governors undoubtedly faced pressure from their colleagues, they not only went against what was statistically predicted – they faced this opposition head on with their terminology.

The second theme that emerged from the literature was this idea of social class opposition – in that the states' population and constituents would be publicly opposed to Medicaid based on this ideology of "deservedness." Based on broad historical disdain for public welfare type programs and the general opposition of the Republican party in the promotion of public social programs versus private or nonprofit charitable contributions, it was believed that the governors

would articulate these same concerns in describing their decision to expand Medicaid. This was supported through the most prevailing theme of this research as advocacy for the disadvantaged. Interestingly, this was also supported through the theme of fiscal responsibility. While Kasich was more openly vocal about his support for the Medicaid expansion as being in direct relation to his compassion for the "*poor, mentally ill, and addicted*", both Sandoval and Martinez articulated this same sense of advocacy for the disadvantaged in their state. This was supplemented with the ideology most purported by Sandoval – second only to Kasich – as being fiscally responsible. By speaking about the Medicaid expansion as being the most beneficial for the most disadvantaged populations, while also framing the financial gains their states would gain from expansion, the governors were likely able to frame their message in a way that not only increased the likelihood of the measure being passed, but as a means of placating the more conservative members of their party.

The third theme that emerged from the literature is one that is less tangibly felt within the data that was collected for this study. Though it was doubtful to assume that any outright racist or coded words would've been used in arguing for their decision-making, one interesting phenomenon did emerge in the analysis; some of the governors – especially Kasich – sought to distance the Medicaid expansion not only as being a part of the ACA, but from President Obama himself. As described in the editorial from the *Lexington Herald Leader*, this dissociation happened often – not just for governors but members of Congress (2014). Further analysis saw an effort to distance the Medicaid expansion from the Affordable Care Act and President Obama himself (Benen, 2014 and Krugman, 2015). Though the expansion is a core component of the federal law, *Politico* reported that Republican governors who expanded argued that Medicaid

was not connected to the ACA but rather was a "reflection of local priorities and unique circumstances" (Cheney and Hohmann, 2014). Indeed, the dissociation of the Affordable Care Act and the Medicaid expansion has remained prevalent not only among elected officials, but among the public. According to a poll from Boise State University, 75 percent of potential voters observed wished for Idaho to expand coverage, while only 35 percent approved of the Affordable Care Act – though the question itself was worded in a way that did not immediately connect the two (Kliff, 2018). As discussed previously, the seemingly cognitive dissonance of associating the Affordable Care Act and by default, President Obama, with the expansion of Medicaid eligibility has remained an interesting, albeit confusing prospect for political scientists and researchers. Similarly, political analysts argued that the expansion of Medicaid – particularly for Sandoval and Martinez – was used as a means for these governors to address the needs of the growing Latino communities in their states, not only as a benefit towards their health but as a way of bringing them towards the Republican party (Wilson, 2013 and Blake, 2012). Though none of the four governors specifically used racialized rhetoric or coded language in their reference to their decision to expand Medicaid, these results could provide the impetus for further research to be completed on this topic.

Though each of the governors presented provide a "snapshot" of the realities that they faced and the emerging themes that they used to describe their decision-making process, recognizing the broader social and political environment that these governors were in could provide greater strength to the trustworthiness of these findings. Therefore, the following chapter will explore a select few Republican governors who also expressed interest in expanding Medicaid but then for a variety of reasons, were prevented from doing so.

CHAPTER 5

MEDICAID OR BUST: A COMPARATIVE ANALYSIS OF STATES WHO DID NOT EXPAND MEDICAID

Around the country, the debate to expand Medicaid was considered to not solely be a policy or political issue, but an ideological one. For many Republicans, choosing to expand Medicaid eligibility was mandating health care coverage – a factor that many argued was not within the rights of the federal government to do so (Alonso-Zaldivar and Christie, 2013). However, as more and more states began to expand Medicaid eligibility, the benefits of expanding Medicaid appeared to outweigh any perceived negatives. As described by Rosenthal, governors are arguably put in the position of being more pragmatic in their decision-making as they not only must appeal to their electorate but must work with their state legislature which may or may not be politically divided (2013). While the four governors in this study faced varying degrees of opposition to their decision to expand – ranging from Dalrymple's legislature "holding their nose to pass" to Kasich being sued for his decision to use the Controlling Board – each of the four governors were ultimately successful in their attempt to expand Medicaid.

However, there is another aspect to this research which this chapter will attempt to provide. While previous research indicated that partisan preference would be more likely to predict the likelihood of a governor choosing to expand Medicaid (Barrilleaux and Rainey, 2014), there were some Republican governors that also attempted to expand Medicaid – and failed. The following provides a brief description of two of these governors and the challenges they faced. This is done with the expectation of providing a thick description of the political and social environment of the United States and to provide a comparison point of understanding the

decision-making and rhetoric of the unsuccessful governors to the four chosen for this study. Thus, the following will be a narrative analysis like the format of Chapter 4, though abbreviated in nature; a full exploration of the issues, challenges, and rhetoric of these two unsuccessful governors would potentially serve as a foundation for future research.

FLORIDA

In what was considered to be one of the closest governors' races in years, Rick Scott was elected to the governorship in November 2010 (Memmott, 2010). His campaign had been marked with issues in relation to his former position as CEO of Columbia/HCA – a hospital chain that had to pay up to $1.7 billion to the federal government in penalties and fines and whose profits were partly fueled from kickbacks to doctors and inflated bills to Medicare and Medicaid (Hensley, 2010 and Department of Justice, 2003). While Scott was never charged and had left the company four months after the inquiry became public (Sharockman, 2010), the accusations of his involvement may have contributed to the problems that he faced in his election campaign, as he won by a 1 percent margin (Fountain, 2010).

Nevertheless, Scott – a vocal critic of President Obama and the ACA prior to his election (Fox News, 2011) – claimed that he looked forward to running the state of Florida similar to that of a business, as a means of increasing state revenue and towards the betterment of the people in it (Allen, 2011). With this mandate in mind, Scott maintained his opposition to the ACA and to the Medicaid expansion (Gaynor, 2012). Following the 2012 Supreme Court ruling, Scott reiterated his views saying in a statement to Fox News, "*We care about having a health care safety net for the vulnerable Floridians, but this is an expansion that just doesn't make any sense*" (Lopez, 2012). Though state advocates argued against this decision as Florida was

considered to have the second-highest rate of people uninsured and a $3.7 billion budget gap (Sack, 2011), Scott was adamant in his opposition, arguing that the financial cost to Florida would add up to $1.9 billion a year, though this claim was later refuted (Sharockman, 2012).

Despite this clear and voracious opposition, Scott made national headlines when he announced he would accept the Medicaid expansion in February 2013 (Cheney, 2013). In an announcement that was a stunning reversal for critics and supporters alike, Scott was quoted as saying, "*When the federal government is committed to paying 100 percent of the cost of new people in Medicaid, I cannot in good conscience deny the uninsured access to care*" (Millman, 2013). Though advocates for the health law were pleased with this reversal (Rovner, 2013), others – including members of his own party – criticized the reversal as nothing more than political conjecture in preparation for his 2014 re-election campaign (Smith, 2014). Others argued that it was not only a desire to improve his election chances, but rather his decision was a result of lobbying pressure faced from hospitals in Florida who advocated strongly for the expansion (Young, 2013c). Nevertheless, Scott attempted to push forward the measure to expand Medicaid but was met with opposition from the state legislature. The Republican-controlled legislature was opposed to the Medicaid expansion (Roy, 2013) and in March of that same year, both the Florida House and Senate rejected the Medicaid expansion (Kliff, 2013).

Scott's reversal led some to question to what extent he truly favored the expansion. In the months leading up to the 2014 midterm election, Scott appeared to be quiet about his former opposition (Health News Florida Staff, 2014) and was criticized not only for his support of the law from members of his own party, but for his lack of persistence in seeing the law pushed through by Democrats (Hatter, 2014). Nevertheless, Scott was ultimately successful in his re-

election bid, winning against his opponent with a 2 percent margin of victory (Associated Press & Mary Shedden, 2014). Though the reasoning behind his reversal remains opaque, his lack of follow-through provides an interesting case study; further research into the specific factors that Scott may have faced, as well as a deeper analysis into the rhetoric and framing that he used would be a useful comparison to the four governors observed.

UTAH

According to polling data in 2014, Utah Governor Gary Herbert was considered to be one of the most popular governors in the country, with a 73 percent favorability rating (Sullivan and Blake, 2014). Unlike Scott, Herbert was not considered to be a vocal opponent to the Medicaid expansion and his announcement that he wished to expand Medicaid was met with praise from advocates (Stewart, 2013 and Stewart and Gehrke, 2014). In his own words, Herbert stated "*Doing nothing… I've taken off the table. Doing nothing is not an option*" (Stewart and Gehrke, 2014). Though advocates were encouraged by the possibility of expanding Medicaid, Republican legislators in Utah were reluctant to move forward with an expansion that was funded by federal dollars (Kliff, 2014).

In his plan to push forward the Medicaid expansion, Herbert released a proposal he dubbed 'Healthy Utah' which would've expanded Medicaid under the federal requirements and opened coverage for up to 126,000 Utahns (Norris, 2018c and Evans, 2016). In his statement to the press on the decision, Herbert is quoted as saying, "*These are our neighbors, our friends and our family members. Turning a blind eye and doing nothing is really not the Utah way*" (Moulton, 2014). However, the Republican-controlled legislature was skeptical and the debate to expand Medicaid continued well into 2015, arguing that there was a disagreement on what would

be the most fiscally responsible thing to do for Utahns (Gehrke and Moulton, 2015). Despite his persistence, the legislature voted against the measure to expand Medicaid time and time again, leading to four failures before Herbert eventually conceded to the legislature (Connolly, 2015, Metcalf, 2016 and Norris, 2018c). Despite these obstacles, Herbert seemed optimistic about the future of expanding Medicaid stating," We *have agreed to start over and see if we can't build a program that we all can support*" (Smardon, 2015). Though a small provision of Medicaid was eventually approved that expanded coverage for up to 16,000 (Davidson, 2016), it was a far cry from Herbert's initial plan to expand without restrictions. Considering the persistence of Herbert despite numerous obstacles, a further analysis into the language he used to describe his support for the Medicaid expansion would also serve as a contrast to the four governors in this study, particularly for Kasich. Although Kasich faced similar opposition and eventually circumvented his legislature, Herbert's persistent work with his legislature – and his potential inability to work around them – provides a comparison to the work in this research. Further analysis into Herbert's circumstances would provide deeper understanding into the restrictions governors faced when deciding to expand Medicaid.

MEDICAID EXPANSION AND THE WILL OF THE PEOPLE

Following the 2018 midterm elections, states such as Idaho, Nebraska, and Utah voted for and approved ballot initiatives to expand Medicaid (Goodnough, 2018). Similarly, governorships in Kansas, Wisconsin, and Maine were won by Democratic leadership, improving the likelihood that Medicaid would be expanded in these states (Hellmann, 2018). Health care was rated as being the highest priority for voters surveyed, with 71 percent stating that it was 'very important' in terms of who to vote for in the election (Kirzinger et al., 2018). The approval of these ballot

measures from Republican-majority states indicated for many that the Affordable Care Act – and specifically the Medicaid expansion – was not necessarily a partisan value, but an American one (Goldstein, 2018).

In support of this, arguments that states would save money by refusing Medicaid appeared to be more unfounded over time. Following an audit of Iowa's privatized Medicaid system, the audit found that the projected $232 million savings purported by former Governor Branstad was inaccurate, with savings from the program being closer to $126 million – just half of the original estimate (Pitt, 2018). The plan led to criticism from providers and patients alike, with many filing complaints that they had been unfairly denied access to care (Clayworth, 2017). These issues, along with the average cost of insuring tripling in one year compared to the previous six (Leys, 2018), illustrate some of the difficulties of implementing cost-saving policies towards patient care. Nevertheless, the support for the Medicaid expansion by the general public may be of interest for future research. Though a comprehensive view of the costs – financially and otherwise – of the Medicaid expansion would require a much deeper, longitudinal study, analysis into the rhetoric and framing of the Medicaid expansion and that relationship with the eventual support from Republican-majority electorates would be of interest for future research.

CHAPTER 6

CONCLUSION

The purpose of this study was to explore the rhetoric and language used by four Republican governors who chose to fully expand Medicaid under the Affordable Care Act despite party-wide opposition to the expansion and the ACA overall. Based on the literature review of this study, it was estimated that three themes – political partisanship, social class opposition, and racial resentment – would serve as explanatory factors for how the governors framed their decision-making. Though the three themes that emerged ultimately differed from the three expected, there is some relation between the two sets. First, recognizing that there was severe political opposition towards expanding Medicaid, each of the governors framed their decision as a means of acknowledging this opposition by pivoting their arguments to the social benefits of expanding. Second, through their assertion that the Medicaid expansion would be a means of helping the disadvantaged in their state, the governors were able to address this ideology while simultaneously describing their decision as an economic benefit to their states. Finally, though none of the governors specifically used racialized rhetoric to describe their decision to expand Medicaid, some political analysts saw that expanding eligibility could be a means of reaching the growing minority population for the Republican party. Additionally, several of the governors used phrasing that distanced the Medicaid expansion from the ACA and President Obama himself. To what extent this distance was given because of partisanship or racial resentment is unclear; further research would be needed on this specific topic to support this premise.

Based on the results of the qualitative content analysis, three major themes emerged from the data: Advocacy for the Disadvantaged, Fiscal Responsibility, and an Appeal to Rationality.

These three themes were further explored in the narrative analysis that followed which described the individual social, political, and economic conditions that Governors Sandoval, Martinez, Dalrymple, and Ohio experienced in the time following their expansion. Though each governor faced unique circumstances which may have led to their decision to expand, all four of the governors framed their decision to expand as a means of aiding those in their state who would benefit from it the most.

Limitations

There are several limitations to this study. Though great effort was made to provide a "snapshot" of the governors' rhetoric in the selected study period, this analysis was limited by the lack of available personal, interview data from the governors themselves. Having interview data from the governors themselves would have increased the trustworthiness of the findings and would have served as a resource for further qualitative content analysis. Similarly, the codes and meanings derived from the text may not be an accurate representation of what the governors intended as this meaning was not only interpreted in retrospect but completed without interviews. Though mistakes, misinterpretations, and errors are possible, the validity of a qualitative research study is not in its replicability, but in its description of the truthfulness in articulating the subject or material studied (Bengtsson, 2016). By providing a detailed account of not only how the data was collected, but how the codes were developed and used for interpretation, the trustworthiness of the study can be increased (Elo et al., 2014). Nevertheless, the study would have benefited from a secondary coder to strengthen that trustworthiness and future research would benefit from that implementation.

Future Research

There are several avenues in which this research could be expanded upon and improved. First, future research into this topic could further explore the social and political factors that contributed to the Republican governors that were ultimately unsuccessful in their attempt to expand Medicaid. Though a brief examination of these ideas is explored in Chapter 5, future research could utilize the same qualitative content analysis and descriptive case study method used in this study as a means of further understanding the issues these governors faced. This type of analysis would not only potentially strengthen the trustworthiness of this study but would increase the contextual understanding of gubernatorial rhetoric and language on the Medicaid expansion and the ACA overall.

Second, though briefly mentioned in Chapter 1, an in-depth analysis into the Republican governors who chose to expand Medicaid using Section 1115 waivers would serve as an interesting counter to the results of this study. Though the four governors in this study chose to expand Medicaid fully without the use of waivers, evaluating how their Republican counterparts were able to pragmatically navigate what has become a lightning rod in the Republican party would serve as an interesting comparison.

Additionally, though a brief discussion of the 2017 'Repeal and Replace' effort can be found in Chapter 2, a full analysis and study of the role that Republican governors played in these efforts' failures would greatly improve the understanding of this topic. Using qualitative content analysis, future research could analyze what emerging themes were found within these governors' rhetoric and evaluate if they are comparable not only to the governors who joined in

standing against the effort, but if it is comparable to the language and rhetoric of the four governors in this study.

Finally, the impact of this research could be examined by analyzing whether the rhetoric used by the four governors of this study was also used by members of their electorate. Considering the increase of ballot measures to expand Medicaid as discussed in Chapter 5, research into how effective the framing tactics of successful governors would be of further interest.

Conclusion

The quiet success of the Medicaid expansion in states – led by both Democratic and Republican governors – may indicate the most supportive argument of the policy itself; despite its beleaguered development and implementation, the Medicaid expansion may prove to be the most lasting, significant aspect of President Obama's legacy. Though the trend towards extreme partisanship continues to develop in the United States (Doherty, 2017), the passage of the Medicaid expansion in these states could serve as an indicator for understanding how to implement future policies that affect the healthcare for the disadvantaged in the United States. Contrastingly, the unique political and social position of the Affordable Care Act's Medicaid expansion could be the specific context in which this policy not only gained traction but became a relative bipartisan success. Though this may not always hold true, as discussed in Chapter 5 with Republican governors who were, for various reasons, unsuccessful in passing Medicaid expansion in their states. As Kingdon discusses in his landmark work *Agendas, Alternatives, and Public Policies*, whether policies are successful may be as much as a product of their content as they are to the timing that they are accomplished (1995).

Therefore, it is imperative for those interested in health care policy to continue research on the fiscal and social effects of the expansion of Medicaid. Though politics and policies do not exist in a vacuum, using healthcare as an ideological battleground ultimately serves no one. If political infighting continues to serve as the rule for healthcare, the ultimate losers will not be either political party, but will be the millions of Americans whose health and wellness served as the collateral damage.

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BIOGRAPHICAL SKETCH

Ariel Arguelles is a doctoral candidate in Public Affairs at The University of Texas in Dallas. She holds two bachelor's degrees, one in Theological-Historical Studies with a concentration in Philosophy and one in Biology, and a Master's in Global Health from the University of Notre Dame. Dedicated to health equity, diversity, and education, Ariel's professional and academic background illustrates her interdisciplinary approach to learning all she can about her greatest passion: people.

CURRICULUM VITAE

EDUCATION

Doctor of Philosophy, Public Affairs Expected May 2019
School of Economic, Political & Policy Sciences, UT Dallas Richardson, TX
Dissertation: *"Policy & Politics: A Case Study on the Rhetoric of Republican Governors on the Affordable Care Act's Medicaid Expansion"*
Co-Chairs: Dr. Richard Scotch and Dr. Meghna Sabharwal

Master of Science in Global Health July 2015
College of Science and the Eck Institute, University of Notre Dame South Bend, IN
Capstone Project: *"Evaluation of the Role of Compassion-Based Training in Non-Clinical Global Health Interventions: A Case Study in Leogane, Haiti"*

Bachelor of Science in Theological/Historical Studies, Philosophy May 2014
College of Theology and Ministry, Oral Roberts University Tulsa, OK
Senior Paper: *The Philosophy of Religion: A Survey of Christianity, Faith and Culture in the 21st Century*

Bachelor of Science in Biology, Pre-Medicine May 2014
College of Science and Engineering, Oral Roberts University Tulsa, OK
Senior Paper: *Effects of Uterine Fibroids on the Reproductive Health of Women*

PROFESSIONAL EXPERIENCE

- **Graduate Student Instructor/Teaching Assistant** The University of Texas at Dallas, Economic, Political and Policy Sciences Department, August 2015 – Current
    - Aided in the development of various professional publications through supplementing literature reviews and providing proofreading/grammar checks
    - Supported on-going research projects as needed such as evaluating journal articles on social media research and contributing to the data analysis of a neuroscience and leadership study.
    - Independently taught Diversity in the Public Sector (Spring 2017/Spring 2018/Fall 2018/Spring 2019) and Human Resources Management (Fall 2017)
- **Student Trainee (Program Analyst)** HHS Office of Inspector General, Office of Evaluations and Inspections, May – July 2018, Dallas, TX
    - Developed draft findings and recommendations for modifying, revising, or implementing procedures to improve the effectiveness and efficiency of programs under review
    - Aided senior program analysts and program staff on program operations for effective implementation of office goals and priorities
    - Contributed to the completion of OIG analysis reports and synthesized research findings toward upcoming work proposals
- **Resource Development Intern**, Sabin Vaccine Institute, May – August 2016

- Competitively selected to participate in The University of Texas System Archer Center Graduate Program in Public Policy, a Washington, D.C. internship and academic fellowship program
- Assisted with planning for the Millennium Campus Conference, held August 1 – 5 at Howard University; prepared background research, supported and coordinated with supervisor on presentation development, developed social media promotion of event, and conducted a presentation during event
- Collaborated with Hogwarts Running Club, Mugglenet, and Feltbeats for social media promotion of #FantasticBeasts5k, a virtual run hosted in support of END7, a sunset grassroots advocacy campaign to raise public support for ending the seven most common neglected tropical diseases
- Managed social media accounts for END7 and part-time for official Sabin account; included daily postings updates, reports on analytics, and preparing daily clippings on news and references to Sabin's missions, goals, and programs

SCHOLARSHIP

Publications

- **Arguelles, Ariel** and John McCaskill. 2018. "Minimizing the Moral Remainder." *Journal of Public Administration and Governance* 8(3): 270-282.
- **Arguelles, Ariel** and Meghna Sabharwal. 2018. "Healthcare For All: An Overview of the Affordable Care Act's Medicaid Expansion." *Indian Journal of Public Administration* 64(2):174-192.
- Arguelles, Ariel. Book Review of "It's a Small World: International Deaf Spaces and Encounters" in *The Social Science Journal* 55(2): 212-213.
- Arguelles, Ariel. Book Review of "Public Personnel Administration: Managing Human Capital (6th Ed)" in *The Indian Journal of Public Administration* 64(2): 322-325.

TEACHING EXPERIENCE

Instructor

- PA/SOC 3379 – Diversity in the Public Sector (Spring 2017, Spring 2018, Fall 2018, Spring 2019)
- PA 3333 – Human Resources Management (Fall 2017)

Teaching Assistant

- PA 4345 – Management of Nonprofit Organizations (Fall 2015)
- BIO 112 – Introductory Biology II (Spring 2012, Fall 2012, Spring 2013)

AWARDS

- President's Teaching Excellence Award for Teaching Assistants, The University of Texas at Dallas, August 2017 – May 2018
- EPPS Department Teaching Assistant of the Year, The University of Texas at Dallas, August 2017 – May 2018

- Archer Fellow Alumni Association First Generation Scholarship, The University of Texas at Dallas, May – August 2016
- Archer Center Graduate Fellow Scholarship, The University of Texas at Dallas, May – August 2016
- Deacon Jim Asmuth Global Health Scholar, The University of Notre Dame, August 2014 – July 2015
- James W. Pugh (Ozark) Scholarship, Oral Roberts University, August 2013 – May 2014
- JDM Foundation Scholarship, Oral Roberts University, August 2011 – May 2014
- Academic Peer Advisor/Tutor Scholarship, Oral Roberts University, August 2011 – May 2014
- Overall Female Academic Peer Advisor of the Year, Oral Roberts University, August 2011 – May 2012
- Dean's Academic Scholarship, Oral Roberts University, August 2010 – May 2014

VOLUNTEER EXPERIENCE

- **The Oxfam Club: The University of Texas at Dallas Chapter**, The University of Texas at Dallas, October 2016 – May 2017, Richardson, TX
- **MSGH Student Advisory Committee**, The University of Notre Dame, January – July 2015, Notre Dame, IN
- **Academic Peer Advisor Program**, Oral Roberts University, August 2011 – May 2014, Tulsa, OK
- **Student Ambassador Program**, Oral Roberts University, August 2010 – May 2012, Tulsa, OK

PROFESSIONAL MEMBERSHIPS AND SERVICE

Associations:

- Pi Alpha Alpha
- American Society for Public Administration
- Beta Beta Beta Biological Honor Society
- Alpha Epsilon Delta
- Minority Association of Pre-Health Students

Service:

Peer Reviewer for:
Public Integrity
Review of Public Personnel Administration