

# Ideology, Party and Opinion: Explaining Individual Legislator ACA Implementation Votes in the States <sup>\*</sup>

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## Abstract

Why do state legislators vote the way they do? Which influence is predominant: ideology, party, or public opinion? The implementation votes surrounding the Affordable Care Act (ACA) provides a unique setting to examine this question, as they make all three considerations highly salient. State roll call votes on ACA implementation were sometimes polarized and sometimes unexpectedly bipartisan. What accounts for the heterogeneity in individual legislator behavior on bills implementing the ACA at the state level? Using new data on legislator ideology and votes from 2011-2015, I show evidence that legislator ideology was by far the most important predictor of voting on implementation votes, far more so than legislator party or public opinion. Moreover, I show the influence of ideology is heterogenous by issue area and bill.

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# 1 Introduction

In the American system of federalism, states are the locus of a tremendous amount of policy making. Even where the federal government intervenes and mandates much cross-state uniformity, as in the Affordable Care Act (ACA) health reform legislation (“Obamacare”), states retain a large degree of discretion in their choices. Nowhere is this more evident than in the implementation of the most public-facing aspects of the ACA. These include decisions on establishing state-level health insurance exchanges and whether or not to expand Medicaid. The stakes were high. The ACA is the most consequential package of health insurance and delivery reforms since Medicaid passed in 1965, with millions standing to gain or lose health insurance coverage based on state decisions under the law.

When it came time to vote on central aspects of the law, state legislators displayed a dizzyingly wide array of behaviors. In Colorado, a Republican controlled House and a Democratic Senate passed a state exchange law that was signed by a Democratic governor. In most other states, Democrats and Republicans were on opposite lines of exchange votes. In Arkansas, both Republican controlled chambers overcame a 75% supermajority threshold to pass Medicaid expansion, initially signed by a Democratic governor and later extended by a Republican. In most other states, Democrats supported expansion and Republicans opposed it. Finally, in states that held votes on the individual mandate, there was very little crossing of partisan lines.

What can we make of this fantastic amount of variation in legislator behavior? Considerations of ideology, party, and public opinion naturally come to the fore. The intense controversy surrounding Obamacare, exemplified by mobilization at the elite and mass levels, should make ACA implementation votes highly salient. While much of what state legislators do is obscure to citizens who may only be half-aware of their statehouse representatives, the drama of votes on, say, Medicaid expansion played out across the pages of dozens of state newspapers.

Two literatures can help us unravel the question of the primary motivators of legislator voting in this area. The first is the more general one of spatial voting, with initial applications to the US Congress (Poole and Rosenthal 1985, 1991). New empirical models of spatial voting, based on past roll call voting behavior, showed how ideology frequently trumped party or constituency interests when explaining roll call votes on individual policies (Poole and Rosenthal 2007). Explanations of state level policy outcomes have distinguished the role of ideology, party, and public opinion or interests (eg Erikson, Wright and McIver 1993; Gray et al. 2004; Lax and Phillips 2009*a*). Yet such applications have been absent at the individual state legislator level, largely because of the absence

of legislator level ideology estimates, with a few notable exceptions (Wright and Schaffner 2002; Aldrich and Battista 2002; Shor and McCarty 2011). The individual level common space ideal point estimates which debuted in Shor and McCarty (2011) offers an opportunity to run models commonplace in the Congressional literature in the states. The implementation votes surrounding the Affordable Care Act (ACA) provides a unique setting to address these old questions in the state politics setting.

A new literature on state implementation of the ACA has paralleled the institutionalization of the Act itself. Jones, Bradley and Oberlander (2014) see national level politics influencing red states' choices differently regarding insurance exchanges since 2011, while Rigby and Haselswerdt (2013) underline state-level factors of partisanship and public opinion. In terms of explaining state opposition to Medicaid expansion, Barrilleaux and Rainey (2014) point to the central role of gubernatorial, and to a lesser extent, legislative partisanship. Jacobs and Callaghan (2013) agree that state partisanship is important in explaining state Medicaid expansion, but add state administrative capacity and path dependence as additional predictors. Finally, Haeder and Weimer (2015) argue that state implementation efforts should be seen in the context of broader patterns of federal-state grant programs.

This literature, despite some dissimilarities, is characterized by major common elements. First, the empirical focus is on states as aggregate units. There is radical heterogeneity at the individual level, however, that is ignored by this overall approach. Not only are there differences between parties, there is quite a lot of variation within parties, both across and within states. The pulls and pushes of a variety of legislator-level factors are of inherent scholarly interest, as cross-pressured legislators have to make consequential and difficult decisions. An individual-level analysis can help us to understand the extent to which partisanship or personal ideology dominate in an increasingly polarized environment. Moreover, missing within-party heterogeneity obscures the possible coalitional strategies that can account for why states as aggregates made the decisions they did.

Next, while the qualitative narrative in these papers emphasizes contextual elements, statistical models frequently eschew such complexity, with dichotomous dependent variables indicating the adoption (or not) of a state-based exchange or Medicaid expansion. Little is done to account for the heterogeneity in the states voting on these provisions, nor to deal with the variation in the bills themselves.

Partisanship is the major predictor of outcomes in this new literature. This is understandable for several reasons. First, the parties have polarized to such an extent that perhaps party is purely synonymous with ideology (McCarty, Poole and Rosenthal 2006; Barber and McCarty 2015). They

are also more cohesive than they have ever been. While the parties *were* internally divided by region as recently as the early 1980s (eg, with Democrats and to a smaller extent Republicans split into northern and southern wings), this is no longer the case. Thus, unified parties should be uniform in their opposition or support for a key pillar of government policy. An alternative perspective sees partisanship as inherently team-based or coalitional. That is, people put aside their personal preferences to push together as teams or coalitions (Cox and McCubbins 1993, 2005; Lee 2009; Noel 2013). Both perspectives are observationally equivalent. Given the prominence of the ACA and its tight association with a Democratic presidential administration (“Obamacare”)—the parties should naturally divide in legislative voting on the issues. Republicans should do all they can to gut Obamacare, while Democrats should do all they can to consolidate it. Not a single Republican in Congress, after all, voted for the ACA—not even moderates like Maine Senators Olympia Snowe and Susan Collins. Yet there remains tremendous ideological heterogeneity within modern American political parties, especially in the states (Shor and McCarty 2011), even if less than in an earlier era (Erikson, Wright and McIver 1993, 2006).

In this new literature, public opinion, outside of Rigby and Haselswerdt (2013), is mostly ignored. This is partly due to the difficulty of estimating state-level opinion on particular issues or general ideology more broadly conceived. Alternatively, analysts could be implicitly assuming public opinion plays no role at all in these kinds of decisions. This assumption is at odds with current research on state-level representation, which assigns a quite significant role for public opinion in state policymaking, especially in highly salient areas (Lax and Phillips 2009*a*), of which ACA implementation would surely count.

So neither state politics more generally, or in state health politics scholarship more specifically, has focused on distinguishing ideological, partisan, and opinion-based influences on individual legislator decisionmaking. This paper is the first to do so for health politics, and one of the first to do so anywhere else in state politics. Individual level explanations can help us to build the micro-foundations of explanations of aggregate policy outcomes, which remain essential but incomplete.

In this paper I show evidence that legislator ideology was by far the most important predictor of voting on implementation votes, far more so than legislator party or public opinion. Moreover, I show the influence of ideology is heterogenous by issue area and bill. The key idea is that there was no single way of establishing a state insurance exchange or of expanding Medicaid. My model flexibly accomodates variation in the impact of ideology on individual votes, in line with the large variation in the content of these bills. The paper is organized as follows. Section 2 goes into more detail on the policy content of these bills. Section 3 describes the data analyzed in this paper.

Section 4 goes through the empirical model and results, and Section 5 concludes.

## 2 The Affordable Care Act in the States

I examine three different sets of legislative choices related to the ACA in the states. The first choice, between state and federal implementation of a health insurance exchange, was explicitly set in the 2010 legislation. The second, whether or not to expand Medicaid, was given by the Supreme Court to the states. The last, whether to symbolically prohibit the individual mandate, was seized by states themselves amidst a temporary lack of clarity of the constitutionality of the provision. I detail these three below.

The ACA gave states the option to establish state-based “American Health Benefits Exchanges,” more commonly known as insurance exchanges or marketplaces, or opt for the default choice of a federal exchange run by the Department of Health and Human Services (HHS). These exchanges determine eligibility and conduct enrollment for Medicaid, State Children’s Health Insurance Programs (CHIP), and new state exchange insurance plans for the individual and small group market. The exchange also determines the appropriate level of subsidies for enrollees in the new marketplace plans. The federal and state exchanges came into operation on January 1, 2014. Some states, typically the liberal ones like California, emerged as early pioneers with regards to state exchanges (Bindman and Schneider 2011).

The big choices states make regard the governance and purchasing models for the exchange. Governance relates to where the organization is located in state government, how independent it is, and who gets to make appointments to its board. With regards to purchasing, the two role models are handily provided by the two states that formed exchanges even prior to the passage of the ACA. After the passage of “RomneyCare” in Massachusetts, its Commonwealth Health Insurance Connector Authority, or colloquially the “Health Connector,” assumed an active purchasing role. That is, it contracted with insurance companies in the state to offer standardized plans that could be purchased by residents. Utah provides the alternative. Under then-Governor John Huntsman (R), the Utah Health Exchange was set up in 2008 to service the small group market. While it did not act as a middleman in purchase transactions, it did establish an information clearinghouse where insurance customers could easily access and compare information on available plans, along with a standardized application and enrollment process. These two roles appear to neatly line up with ideological predispositions. On the one hand, proponents of an active and large role for government in regulating market activity should support the active purchaser model. A state government with almost monosponistic buying and bargaining power could then more easily muscle desired insurance

product offerings and prices from private companies. Alternatively, it could eschew such authority by adopting the clearinghouse model.

The fireworks surrounding *National Federation of Independent Business (NFIB) v. Sebelius* were focused on the individual mandate, which came within one vote of being struck down as unconstitutional. Relatively little attention was paid to Medicaid expansion before the case was decided, where states complained on federalism grounds that they should not be forced to expand Medicaid to all uninsured adults below 138% of the federal poverty level (FPL). Yet, this time by a 7-2 margin, it was mandatory Medicaid expansion that the Court struck down.<sup>1</sup> States could now choose to expand Medicaid with the federal government picking up 100% of the cost for the newly-eligible from 2014 through 2016, and 90% of the cost thereafter. If they chose not to expand their Medicaid programs, the old programs would continue to be subsidized by Washington as before.

This decision is extremely consequential to the implementation of the ACA. The Kaiser Family Foundation estimates that, as of September 2016, more than 2.5 million adults would have been covered by the 19 states refusing to expand Medicaid.<sup>2</sup> And unlike the insurance exchanges, there is no fallback option in case a state decides not to expand. This means the stakes of state decisions to expand Medicaid are even higher than that for the exchanges. Ironically the hopes of the Obama Administration and progressive health policy reformers were and are tied up with the choices of their ideological opponents.

Furthermore, the menu of options that is explicitly spelled out for health insurance exchanges is not present for Medicaid expansion, precisely because of the unanticipated Supreme Court decision. Yet, despite the formal silence of the ACA on expansion options, some de facto choices have emerged, both as a consequence of existing law and of administrative, unilateral decisions by the Obama administration. States have always had the right which has been extensively employed to seek Social Security Act Section 1115 demonstration waivers to reform traditional Medicaid, and these have become the de facto vehicle for modified expansions post-*Sebelius*. Statutes require Medicaid reforms performed through waivers to be “cost effective,” which on its face would seem to rule out any experiments that cost more than the budgeted expansion cost for the state. The Obama Administration HHS also explicitly disallowed partial expansions—such as those that lower the eligibility threshold below 138% of the FPL. It has also demanded that Medicaid’s unique benefits, including very low copays, little or no deductibles, and others like transportation assistance, be provided in any state Medicaid waiver. Nevertheless, after several years of granting waivers to

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<sup>1</sup>The conservatives were united on this decision, and the liberals were split with Breyer and Kagan agreeing with the conservatives and Ginsburg and Sotomayor opposed.

<sup>2</sup>See <http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expa>

relatively more conservative states, there was effectively a zone of uncertainty about what was acceptable in terms of Medicaid expansion other than the plain-vanilla variety described explicitly in the ACA.

Arkansas' Medicaid expansion law in 2013 was the first and the most consequential. Pushed by then-Democratic Governor Mike Beebe to convince a newly-emergent and skeptical Republican majority in the state legislature, it was eventually passed over a 3/4 supermajority requirement, after Beebe had won approval for the waiver from the HHS. Arkansas' expansion was renewed in two separate votes in 2014 and 2015, the latter being particularly impressive with a two-year renewal done at the behest of newly elected Republican Governor Tim Hutchinson. Following Arkansas, five other states have sought and won Section 1115 waivers: Iowa, Michigan, Indiana, New Hampshire and Montana.<sup>3</sup> All these have typically included several of the following elements: modest premium requirements from beneficiaries, participation in the state insurance exchange instead of traditional Medicaid, "healthy behavior incentives," and work referrals.

After *Sebelius*, the individual mandate became a purely symbolic issue, but numerous bills were voted on prior to that date, when its constitutionality was still in question. The individual mandate emerged as a central complaint by conservatives on both policy and legal levels. A substantial number of anti-mandate provisions were passed in numerous states. Even after the decision, a number of states are continuing in passing these resolutions, including at least three referenda held in November 2012. While the constitutionality of the mandate was indeed in question at a national level, state legislators surely knew, legally speaking, that they could not refuse the application of a legal federal mandate on their states' citizens. While these symbolic votes are less interesting from a policy perspective, they does provide a useful placebo to examine more concrete and potentially compromisable choices in those two spheres.

## 3 Data

### 3.1 ACA related roll calls

The dependent variable I am seeking to explain are individual state legislators' votes from 2011 to 2015 in ACA implementation floor votes in the categories of state exchange implementation, Medicaid expansion, and anti-mandate provisions. Summary statistics on these votes and roll calls are in Table 1, and further details in the online appendix. These include 10,950 votes on 94 different

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<sup>3</sup>Pennsylvania under newly-elected Democratic Governor Tom Wolfe revoked the Medicaid waiver granted under his Republican predecessor Corbett.

bills and 144 roll calls<sup>4</sup>, across 43 separate states.<sup>5</sup> These health care roll call votes are taken from a combination of Project Vote Smart’s key votes bill database and the OpenStates data project.<sup>6</sup>

	HIX	Medicaid	Mandate
Number States	25	24	19
Number Bills	37	35	21
Number Roll Calls	59	52	33

**Table 1:** *Summary counts of ACA related bills.*

### 3.2 Party and the ACA

A simple way to begin is with Table 2 which gives us some preliminary evidence about how the issues split the parties across states (pooling the states together). HIX and Medicaid expansion splits Republicans in state legislatures, while votes on the mandate do not. Democrats, on the other hand, are unified on these provisions, while a small minority split on the mandate. But can more than a quarter of Republicans voting yes on exchanges and a fifth on Medicaid expansion count as a true split? Yes, it can, for a number of reasons. First, these are simple averages which mask considerable heterogeneity at the state level; in some states, there was a *majority* of Republicans in favor of these provisions, in others, they were unified in opposition. Second, given that the ACA passed without a single Republican vote in Congress, in an age of polarization (Shor and McCarty 2011) even a minority of Republican state legislators voting with Democrats can be scored as bipartisan.

	No	Yes		No	Yes		No	Yes
Democrat	0.05	0.95	Democrat	0.01	0.99	Democrat	0.92	0.08
Republican	0.72	0.28	Republican	0.80	0.20	Republican	0.03	0.97
(a) HIX Implementation			(b) Medicaid Expansion			(c) Individual Mandate		

**Table 2:** *Partisan splits on ACA-related bills in the states.*

That state level heterogeneity becomes obvious when I break out the votes by party, state, and policy area as seen in Table 3. Republicans are very heterogenous across states on state health insurance exchange votes, with near-unanimous votes in favor of in Arkansas and North Carolina,

<sup>4</sup>Quite a few bills progressed no further than a vote in a single chamber.

<sup>5</sup>Since these votes are conditional on bills being presented on the floor for a vote, obviously my bill data does not represent the universe of ACA implementation lawmaking across the states. In some states, governors unilaterally enacted insurance marketplaces or Medicaid expansion. In other states, these bills were killed in committee, died upon the end of the legislative session, or otherwise bottled up in the lawmaking process. Bills with fully unanimous roll calls are dropped as these leave no variation to be leveraged for explanation.

<sup>6</sup>See <http://votesmart.org/issues/NA/91> and <http://www.openstates.org> for more detail.



to undivided opposition in states like Arizona, Maine, New Jersey, and West Virginia, and a range of states in between. Democrats on exchanges and the mandate and Republicans on Medicaid expansion are moderately variable. Republicans, for example, swing between majority support for expansion in a state like Arkansas to near-complete opposition in many other states. There is almost no variation by Republicans on the mandate and Democrats on Medicaid expansion.

The outcome of roll calls on the three ACA-related provisions in state legislative chambers is detailed in Table 4. It shows very clearly the different paths taken by bills in the different areas. Mandate prohibition bills were the simplest and most partisan; these were typically passed in Republican-majority chambers, although two actually passed Democratic-majority chambers by rolling the majority. Health insurance exchange bills were mostly passed in chambers with Democratic majorities, but a good number passed in Republican-majority chambers. Republicans were rolled twice on these bills. On the other hand, in about a third of the cases, a majority of Republicans voted in favor of state insurance exchange implementation. Finally, Medicaid expansion provides the most complex and interesting example. These bills were passed in both Republican and Democratic-majority chambers, though unsurprisingly more in the latter. Republican majorities were rolled an astounding 12 times, or over half the frequency they passed Republican chambers. A majority of Republicans voted in favor of expansion 9 times, irrespective of majority status. Medicaid expansion, thus, shows how frequently legislative Republicans were either rolled or supported expansion outright. This is quite a different image from the national Republican position of implacable opposition to Medicaid expansion.

State	D Exchange	R Exchange	D Medicaid	R Medicaid	D Mandate	R Mandate
AK					0.13	0.88
AL			1.00	0.00	0.12	0.99
AR	1.00	0.90	1.00	0.64		
AZ	1.00	0.00	1.00	0.29	0.00	1.00
CA	0.99	0.03	1.00	0.09		
CO	0.98	0.28	1.00	0.13		
CT	1.00	0.27				
FL			1.00	0.27	0.04	1.00
GA			1.00	0.01		
IA			1.00	0.00		
ID	0.95	0.52			0.00	0.90
IL	1.00	0.69	0.94	0.16		
IN					0.04	0.90
KS			0.95	0.18	0.21	0.92
LA					0.42	1.00
MD	0.99	0.23	0.99	0.05		
ME	0.98	0.00	1.00	0.06		
MI	1.00	0.52	0.98	0.42		
MN	1.00	0.00	1.00	0.08	0.00	0.96
MO					0.16	1.00
MS	0.93	0.56				
MT			0.99	0.22	0.01	0.97
NC	0.34	1.00	0.98	0.00	0.04	1.00
ND	0.80	0.14	1.00	0.49		
NE			1.00	0.29		
NH	0.98	0.05	0.99	0.08	0.00	0.96
NJ	0.94	0.00	1.00	0.08		
NM	0.88	0.45				
NY	1.00	0.15				
OH					0.02	1.00
OK					0.26	1.00
OR	0.98	0.68				
PA					0.00	1.00
RI	0.80	1.00				
SC	1.00	0.67	1.00	0.00		
TN			1.00	0.00	0.14	1.00
UT			1.00	0.32		
VA	0.90	0.07				
VT	0.96	0.05				
WA	0.98	0.22				
WI					0.00	1.00
WV	0.98	0.00				
WY			1.00	0.18	0.14	0.92

**Table 3:** Partisan support for ACA-related bills, aggregated by state, and displayed in proportions. Heterogeneity is highest on exchange bills, next highest on expansion bills, and lowest on mandate bills.

	HIX	Medicaid	Mandate
Roll Calls Passed	53	40	33
R Majority Passed	11	21	31
D Majority Passed	44	19	2
R Majority Rolled	2	12	0
D Majority Rolled	0	0	2
R No-Rolled	18	9	33
D No-Rolled	51	40	0

**Table 4:** *Information on ACA-related bill roll call outcomes within chambers. Majority passed refers to roll calls passed with Republican and Democratic majorities (Oregon’s House had split control in 2011-2012, and passage of two bills under joint majorities accounts for double counting in rows 2 and 3 of first column). Rolls refers to bill passage with only minority support of a partisan majority. No-rolls refer to passage with majority support of a party, in and out of majority control.*

### 3.3 Bill Characteristics

Who are these Republicans voting for insurance exchanges and Medicaid expansion? Health care is a classically “first dimension” issue; it touches on the core dispute between left and right, which is the extent of government control over private market activity via regulation and redistribution. Thus, our expectation should be that conservative ideology should be inversely related to the likelihood of voting for both of these policies, and positively related to the likelihood of voting symbolically against the individual mandate.

In reality, the question is somewhat more complicated, for several reasons. First, insurance exchanges could be construed as a conservative or free market solution to cost and access problems in the health insurance market, enabling consumers to make better choices and through competition improve the performance of the health insurance market. This was explicitly discussed by then-Governor Mitt Romney as well as the conservative Heritage Foundation in Massachusetts in 2005-6. The same was true of the Utah health insurance exchange implemented in 2008. There, the vision was of a web site like Orbitz that aggregated relevant details about insurance plans. On the other hand, it is difficult to build the case that conservatives can find something to like in traditional Medicaid expansion, which involves making public provision of health insurance coverage even bigger.

Second, the ACA radically shifts the status quo policy location. For states refusing their own exchanges, federally facilitated exchanges (FFE) run by HHS are imposed on that state.<sup>7</sup> If a state decides to leave the FFE, it can do so later, but only with HHS approval—and without federal dollars. Thus, the choice faced by conservative state legislators is voting for a state exchange closer to their preferences, or accepting the new status quo of a federal exchange, potentially run by a liberal administration. While the substantive choice can be clear, the symbolism of voting for an exchange may outweigh those benefits, especially given the close association of exchanges with President Barack Obama.

An example of the conservative dilemma comes from Colorado. A “clearinghouse” exchange (similar to Utah) was negotiated by Democratic Senator Betty Boyd and Republican House Majority Leader Amy Stephens in early 2011. Stephens hails from ultra-conservative Colorado Springs and is extremely conservative herself. The resulting compromise, SB 200, was supported by all major business groups, including the local chapter of NFIB—the national organization of which joined the lawsuit against the ACA with 27 state attorney generals. Still, the emerging legislation was

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<sup>7</sup>There is an intermediate step called a partnership model, where decisionmaking is split between a state and the federal government.

met with massive Tea Party opposition against so-called “Amynicare” in spring 2011, and she went on to face high quality primary challengers in the next election who campaigned on the issue. Nevertheless, Stephens argued against “den[ying] Colorado the opportunity to control its own destiny, and sitting on our hands waiting for the court to decide.” In June 2011 it passed both chambers with divided Republican support, and was signed by Democratic Governor Hickenlooper.

The conservative divide has continued in the wake of the Supreme Court decision largely upholding the ACA. Some governors and state legislators continue to make the case that a self-designed plan is superior to the FFE. Donald Hughes, Arizona Governor Jan Brewer’s health care policy advisor, was recently quoted as saying, “If we have to have one, then it would be better for Arizona to do it ourselves rather than defer to the federal government.”<sup>8</sup>

Yet for all this, insurance exchanges were relatively less controversial during the debates over the ACA in 2009 and 2010. The individual mandate, and to a lesser degree, Medicaid expansion, centered in opponents arguments against the reform. Yet, in 2013, things changed. Legal arguments from Case Western Reserve professor Jonathan Adler and CATO Institute scholar Michael Cannon convinced many states inclined to pursue a state-based exchange not to proceed further. They argued that, given the text and history of the statute, a federal fall-back exchange would not be able to provide subsidies for individuals on the exchange, effectively undoing a large portion of Obamacare in that state. Cases featuring this line of argument began to conflict in the circuit courts in 2014, and the Supreme Court granted *certiorari* and heard arguments on *King v Burwell* in March 2015. A 5-4 decision in favor of the Obama Administration was handed down in June 2015. What is key from this paper’s perspective is that such arguments made to conservative state legislators (through blogs or ALEC meetings) should amplify the effect of ideology in determining a legislator’s vote on exchange implementation.

In terms of Medicaid, the status quo might appear to be unchanged. After all, the Supreme Court ruled that the federal government can not penalize states refusing to expand their Medicaid programs. On the other hand, forgoing 100% funding for two years and 90% funding thereafter must be counted as an opportunity cost of saying no to expansion, especially with many health care facilities struggling with uncompensated care. This is especially the case for the many states who supplement their Medicaid programs with their own funds above their mandated amounts. In this case, even conservatives have to reckon seriously with the costs and benefits of this policy in a concrete, rather than purely symbolic sense.

For liberals, a yes vote appears rather straightforward in both instances. Substantively, ex-

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<sup>8</sup> *New York Times*, September 23, 2012, p. A1.

changes (plus subsidies) and Medicaid expansion implement the access and cost reforms that have been a liberal priority for so long. Politically, association with Obama’s biggest domestic policy victory is a no-brainer. A very small minority of Democrats have argued against particular implementations of state insurance exchanges, claiming an overly strong role for health insurance companies in the governance of the exchanges in particular states.

For symbolic votes on the individual mandate, we would expect these strategic factors to be less salient. Moreover, the contextual differences across states are minimized; the mandate is identical everywhere. The only relevant difference would be cross-state ideological differences. It is possible that there are Republicans liberal enough or Democrats conservative enough to vote in an unexpected direction.

### **3.4 Legislator Ideology**

At a basic level, spatial politics posit legislators that compare bill locations on some dimension with that of the status quo, and vote for the former if it is closer to their ideal point, and latter if not. Empirical implementations of the spatial voting model have relied on ideal points estimated from past roll call votes, using NOMINATE (Poole and Rosenthal 1997, 2007) or an item-response model (Clinton, Jackman and Rivers 2004).

However, this has not been the case for state legislators. Shor and McCarty (2011) debuted a new data set of legislator-level ideal points that are in a single-dimensional common space to facilitate cross-state comparisons. These are based on using roll call votes in the state legislatures to estimate state-specific legislator ideal points. These are then projected into common ideological space using candidate survey data from Project Vote Smart that has been continually administered in largely identical form every state and federal election cycle since 1996. Since the candidate surveys ask the same questions across states and time, it allows me to place ideological estimates from within individual states in common, comparable ideological space. The data is not subject to the vagaries of vastly different legislative agendas in the states. The original version of the Shor-McCarty data extended only through 2008. This paper uses a newly-updated version of that data set that extends to 2016, and covers many state-years missing in interim updates.

### **3.5 District Opinion**

District opinion might matter directly if legislators feel that voters or interest groups are likely to pay close attention to these votes, which are quite likely to be salient. Nyhan et al. (2012) has

argued—in the context of Congressional elections—that the Affordable Care Act is uniquely salient and taps district opinion in a way that other roll call votes do not. It remains to be seen if the same dynamic operates at the state legislative district level.

To evaluate whether district opinion is an additional factor, we need measures of district-level public opinion. This is difficult to accomplish, as sample sizes on even very large national surveys are insufficient. One response to this problem is *disaggregation* at the district levels (Tausanovitch and Warshaw 2013). Here, multiple national polls are pooled so as to generate sufficiently large sample sizes by district. The principal difficulty of such a method is the sheer amount of data required, which often necessitate pooling polls over a decade or more.

I use three measures of district preferences. The first is the simplest. Presidential vote is a traditional proxy for district ideology (Levendusky, Pope and Jackman 2008; Kernell 2009). This is because the presidential vote in recent years has largely become an ideological choice between two polarized, alternative visions of government. Specifically, I use district deviations from the national average of the 2008 election (for votes taken in 2012 or earlier, using pre-redistricting districts) or 2012 presidential vote (for votes taken in 2013 or later, using post-redistricting districts).

As a more direct alternative to either disaggregation or presidential vote, I turn to modeling aggregate opinion with multilevel regression combined with poststratification (MRP), which has been shown to offer excellent recovery of state-level opinion estimates with minimal data requirements (Park, Gelman and Bafumi 2004; Lax and Phillips 2009*b*). Here, opinion is modeled with both demographic information and non-demographic geographic effects. Mechanically, after the multilevel model is estimated, predictions are made for each demographic-geographic respondent cell. Then, these predictions are poststratified by detailed Census population data about the sizes of these cells in the districts. Warshaw and Rodden (2012) conduct similar exercises for state Senate districts and find that MRP efficiently estimates opinion despite the extreme sparseness of the data. Given how much more numerous are state House districts and how much more taxing on the limited data, I will estimate opinion for upper chamber districts only. Details of the MRP procedure can be found in the online Appendix.

Survey data comes from a 5,000 respondent survey conducted by Survey Sampling International, funded with a pilot grant from the Robert Wood Johnson Foundation. Respondents were asked of their opinion on the Affordable Care Act, with identical wording to polls conducted monthly over years by the Kaiser Family Foundation.<sup>9</sup>

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<sup>9</sup>“As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally (favorable) or generally (unfavorable) opinion of it?”

## 4 Analysis

### 4.1 Model

I model individual level votes in the context of a multilevel model with varying intercepts for the bills, and varying slopes for the ideology effect across bills. In addition to its more efficient use of data, a multilevel model is preferred to a classical alternative because of its generality. They avoid a stark choice between complete pooling or ignoring contextual differences across units, or no pooling (often called fixed effects) which implies ignoring differences across units. The extent of the multilevel’s partial pooling is dictated by the data.<sup>10</sup> I fit more restricted models with only varying intercepts and a more general model with both varying intercepts and slopes and obtain substantially similar results. The varying intercepts and slopes models showed considerable improvements in model fit.

### 4.2 Results

Tables 5, 6 and 7 show the results for a related set of models for all three provisions. Note that results are standardized for comparing coefficient sizes within-model only. When considering party alone (column 1 in each table), Republicans and Democrats vote in the expected direction. The same is true for legislative conservatism (column 2 in each table); the more conservative the legislator, the more likely a “Nay” vote on HIX implementation and Medicaid expansion, and a “Yea” vote on prohibiting the mandate. Model fit improves significantly comparing party- and ideology-only models. Combining the two in columns 3 and 4 (with varying slopes by ideology in the latter) we can see how much the effect of legislator ideology dwarfs party. Party remains statistically significant, but its magnitude shrinks dramatically in all provisions. The varying intercepts plus slopes specification in column 4 outperforms the varying intercepts-only specification in column 3, and is the preferred specification, given the improvements in model fit on multiple measures and over all three provisions.

Because the coefficients from a logit model are hard to interpret, I plot the predicted probability of a yes vote on a select portion of these bills. These are shown in Figure 1. Overall, errors in model predictions are where we would expect them to be – closer to the cutline. Democrats and Republicans that vote against the expected partisan vote are nearly always moderate. Notable are the differences in the predicted probability curvature, even within implementation areas. This is

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<sup>10</sup>See, for example Western (1998); Raudenbush and Bryk (2002); Gelman (2005); Gelman and Hill (2006); Bafumi and Gelman (2006); Shor et al. (2007).



**Table 5:** *HIX Implementation*

	Party Only	Ideology Only	Combined	Combined VS
	(1)	(2)	(3)	(4)
Party (1=R)	-4.87*** (0.14)		-2.05*** (0.27)	-0.59* (0.34)
Conservatism		-6.06*** (0.19)	-3.68*** (0.34)	-8.77*** (1.45)
Constant	1.65*** (0.24)	1.86*** (0.31)	1.79*** (0.28)	1.61*** (0.42)
PCP	89.2	90.8	90.9	92.7
PRE	67.8	72.8	72.8	78.2
ePCP	83.9	84.5	85.0	89.7
AUC	93.2	94.6	94.5	98.1
Varying Intercept by Bill	Yes	Yes	Yes	Yes
Varying Slope by Bill	No	No	No	Yes
Observations	4,290	4,305	4,290	4,290
Log Likelihood	-1,295.37	-1,262.63	-1,225.10	-835.98
Akaike Inf. Crit.	2,596.75	2,531.25	2,458.21	1,683.97
Bayesian Inf. Crit.	2,615.84	2,550.36	2,483.67	1,722.15

*Note:*

\*p&lt;0.1; \*\*p&lt;0.05; \*\*\*p&lt;0.01

**Table 6: Medicaid Expansion**

	Party Only	Ideology Only	Combined	Combined (VS)
	(1)	(2)	(3)	(4)
Party	-7.34*** (0.30)		-1.73*** (0.39)	-1.65*** (0.43)
Ideology		-11.48*** (0.47)	-9.81*** (0.58)	-13.10*** (1.28)
Constant	1.78*** (0.28)	2.65*** (0.45)	2.76*** (0.45)	3.55*** (0.60)
PCP	90.6	93.1	92.9	93.4
PRE	83.9	88.2	87.7	88.6
ePCP	86.3	89.9	90	90.5
AUC	96.4	98.2	98.3	98.6
Varying Intercept by Bill	Yes	Yes	Yes	Yes
Varying Slope by Bill	No	No	No	Yes
Observations	4,116	4,128	4,116	4,116
Log Likelihood	-985.50	-764.65	-751.81	-718.77
Akaike Inf. Crit.	1,977.01	1,535.30	1,511.62	1,449.54
Bayesian Inf. Crit.	1,995.98	1,554.27	1,536.91	1,487.48

*Note:*

\*p&lt;0.1; \*\*p&lt;0.05; \*\*\*p&lt;0.01

**Table 7: Oppose Mandate**

	Party Only	Ideology Only	Combined	Combined (VS)
	(1)	(2)	(3)	(4)
Party	6.95*** (0.31)		0.76 (0.49)	1.07* (0.57)
Ideology		9.31*** (0.47)	8.36*** (0.74)	9.96*** (1.27)
Constant	1.63*** (0.29)	1.85*** (0.29)	1.83*** (0.29)	2.38*** (0.48)
PCP	95.1	95.8	95.7	96.1
PRE	92.8	93.8	93.7	94.2
ePCP	91.7	93.3	93.3	93.6
AUC	97.4	98.4	98.4	99.0
Varying Intercept by Bill	Yes	Yes	Yes	Yes
Varying Slope by Bill	No	No	No	Yes
Observations	2,515	2,517	2,515	2,515
Log Likelihood	-439.67	-344.33	-342.97	-328.26
Akaike Inf. Crit.	885.34	694.66	693.95	668.53
Bayesian Inf. Crit.	902.83	712.15	717.27	703.51

*Note:*

\*p&lt;0.1; \*\*p&lt;0.05; \*\*\*p&lt;0.01

dramatically visible in the top row, with a more typical negative slope for Colorado’s SB 200 and a rarer positive slope for North Carolina’s HB 115 (where liberal activists decried corporate influence on exchange structure).

While the estimated *average* effect of ideology is in the expected direction for all three types of votes, it is useful to inspect the distribution of varying slopes for ideology. Figure 2 displays histograms of the slopes. For Medicaid expansion and mandate prohibition votes, the slope for ideology does vary (especially for the former), but all are in the expected direction. That is, in no bill does being more conservative translate into a greater probability of voting for Medicaid expansion and against the mandate. This is also true of nearly all insurance exchange bills. For four bills, however, that is not the case. In these bills, the slope is positive, indicating that exchange legislation opposition comes from liberal legislators. Examples include SB 87 in Rhode Island, SB 221 in New Mexico, HB 115 in North Carolina, and SB 163 in New Hampshire. This might imply that the legislation in that state could have been written in a more liberal fashion without jeopardizing passage.

The models in Tables 5, 6 and 7 perform rather well. The percent correctly classified for the three varying slopes models (column 4) are 92.7% (exchange implementation), 93.4% (Medicaid expansion), and 96.1% (mandate). This compares favorably with the null model, or the percent modally classified, with a 78.2%, 88.6%, and a 94.2% proportionate reduction in error (PRE) over that baseline.<sup>11</sup> These classical fit statistics are now increasingly deprecated, however (Herron 1999; Greenhill, Ward and Sacks 2011). One extremely simple alternative is “expected PCP” or ePCP (Herron 1999), which is a correction to the more traditional PCP that gets away from using an arbitrary threshold like 50%. It can be described as the average of the probabilities that the model predicts for each observation. In the three models, the ePCP statistic is telling us that 90-94% of the probability density is assigned to the correct outcome. Another alternative is the Receiver Operating Characteristics (ROC) curve, which describes the tradeoff between the true positive rate (sensitivity) and the false positive rate (specificity) with a varying threshold. Well fitting models are those with curves that come closest to the upper left hand corner of the ROC curve; these have the highest ratio of a true positive rate relative to false positive rate, and a correspondingly high area under the curve (AUC). The three models have AUC statistics of 98-99%, which are considered very high. Finally, the separation plot in Figure 3 is a new visualization of dichotomous model fit from Greenhill, Ward and Sacks (2011). In an extremely informationally dense plot, we can see

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<sup>11</sup>The null model predicts that everyone votes according to the modal response, which in this case is yes. A “prediction” here is considered at a baseline of 0.5. That is, a fitted value for an observation above 0.5 is counted as a 1, below as a 0.

that the model does a very good job in assigning high predicted probabilities to outcomes of 1 (eg, a vote for HIX implementation or Medicaid expansion, or a vote in favor of banning an individual mandate), and low probabilities to the 0 outcome. We can do better in evaluating model fit, by breaking down the predictions of the model by party; the results of this exercise are found in the Appendix. In short, the models do a very good job for both Democrats and Republicans, providing a tougher null than the modal vote. The fits are slightly better for Democrats than Republicans for insurance exchanges and expansion, and worse on the individual mandate.

### 4.3 Opinion

I examine district opinion in Tables 8, 9 and 10, one for each of the three ACA provisions.<sup>12</sup> When entered individually, districts with more conservative opinion are associated with legislators voting in the expected directions. This is true of upper and lower chamber districts with presidential vote data, and upper chamber districts with MRP estimates of both overall conservatism and ACA approval. Yet when added to the combined model, we see the same dynamic as party. While coefficients for the other predictors barely move, that for the three measures of opinion falls to insignificance. So, independent of the effect that more extreme districts elect more extreme representatives, public opinion is remarkably ineffective in pressuring legislators to vote in accordance with their preferences.

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<sup>12</sup>I separate presentation of these models from the previous set of tables because I have three measures of opinion.

**Table 8:** *HIX Implementation with District Opinion (Varying Slopes)*

	Pres Vote	Pres Vote	ACA Opinion	ACA Opinion	District Opinion	District Opinion
	(1)	(2)	(3)	(4)	(5)	(6)
Conservatism		-8.69*** (1.54)		-11.90*** (3.14)		-11.56*** (2.99)
Republican (R=1)		-0.87** (0.38)		-0.45 (0.87)		-0.57 (0.87)
Dem Pres Vote	3.47*** (0.15)	0.13 (0.26)				
ACA Conservatism			-3.40*** (0.44)	0.72 (0.71)		
District Conservatism					-2.57*** (0.33)	0.92 (0.63)
Constant	1.23*** (0.22)	1.60*** (0.47)	1.39*** (0.33)	2.13*** (0.58)	1.23*** (0.29)	2.10*** (0.55)
PCP	80.2	92.3	75.4	94.0	74.6	94.0
PRE	70.5	88.5	65.5	91.5	64.3	91.5
ePCP	70.1	89.2	67.7	90.7	66.9	90.6
AUC	84.6	97.9	81.3	98.3	79.9	98.2
Observations	3,920	3,909	866	864	866	864
Log Likelihood	-1,866.80	-790.14	-452.59	-179.57	-461.94	-179.04
Akaike Inf. Crit.	3,739.59	1,594.28	911.18	373.14	929.88	372.09
Bayesian Inf. Crit.	3,758.42	1,638.18	925.47	406.47	944.17	405.42

Note:

\*p<0.1; \*\*p<0.05; \*\*\*p<0.01

**Table 9: Medicaid Expansion with District Opinion (Varying Slopes)**

	Pres Vote	Pres Vote	ACA Opinion	ACA Opinion	District Opinion	District Opinion
	(1)	(2)	(3)	(4)	(5)	(6)
Conservatism		-13.62*** (1.62)		-12.24*** (2.11)		-12.37*** (2.10)
Republican (R=1)		-1.85*** (0.50)		-4.19** (1.65)		-4.11** (1.64)
Dem Pres Vote	4.57*** (0.19)	0.22 (0.34)				
ACA Conservatism			-3.16*** (0.42)	-0.35 (0.71)		
District Conservatism					-2.25*** (0.30)	0.18 (0.64)
Constant	0.87*** (0.27)	4.19*** (0.75)	0.73*** (0.25)	5.02*** (1.19)	0.62*** (0.20)	4.93*** (1.18)
PCP	80	92.2	72.4	93	72.2	92.6
PRE	53.4	81.9	55	88.6	54.6	88
ePCP	71.5	88.8	63.7	89.4	62.4	89.3
AUC	87.8	98.1	79	98.4	77.2	98.4
Observations	3,028	3,017	1,020	1,018	1,020	1,018
Log Likelihood	-1,383.42	-619.58	-580.46	-226.10	-594.46	-226.18
Akaike Inf. Crit.	2,772.84	1,253.16	1,166.92	466.19	1,194.92	466.37
Bayesian Inf. Crit.	2,790.89	1,295.24	1,181.70	500.67	1,209.70	500.84

Note:

\*p<0.1; \*\*p<0.05; \*\*\*p<0.01

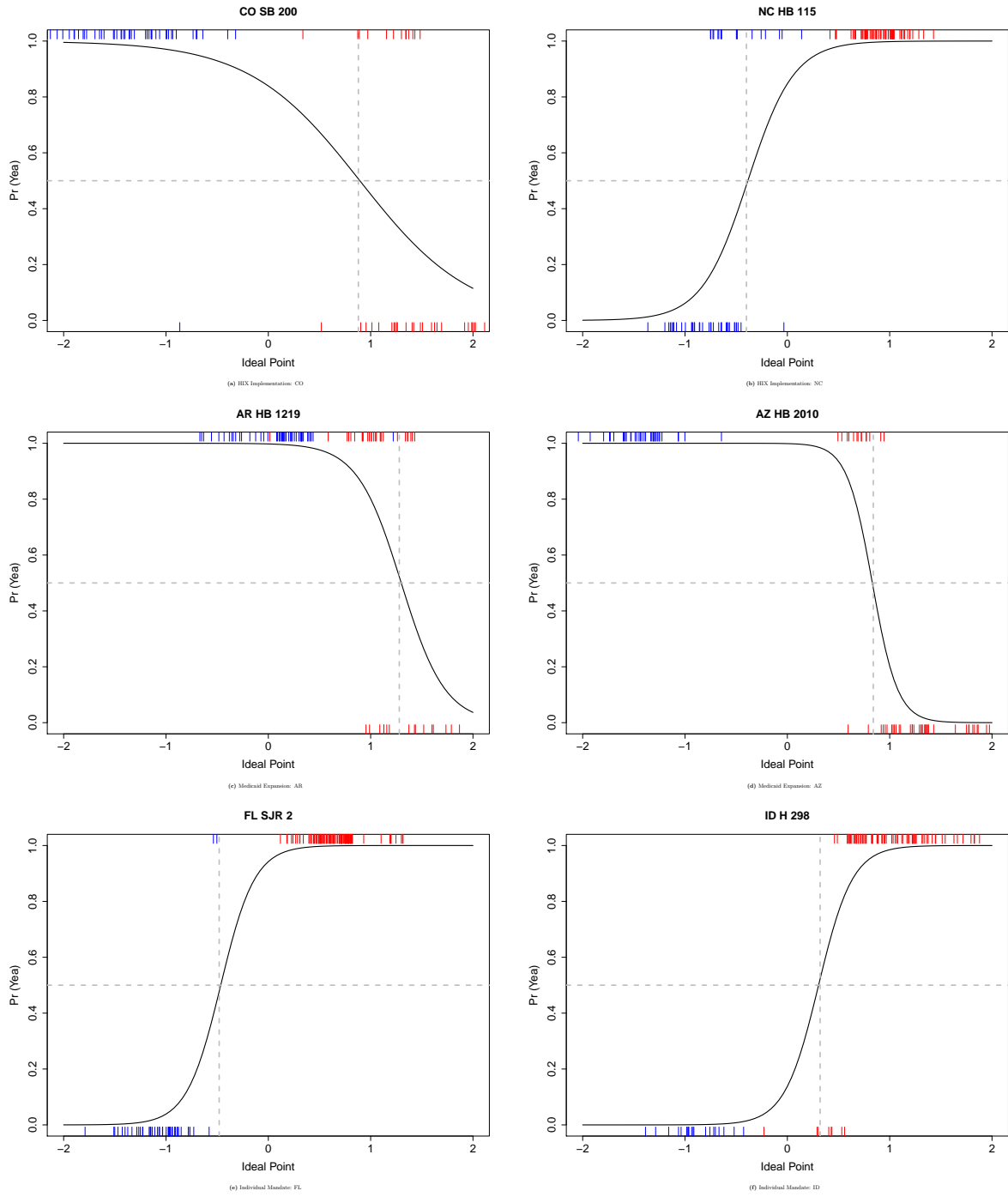
**Table 10:** *Prohibit Mandate Models with District Opinion (Varying Slopes)*

	Pres Vote	Pres Vote	ACA Opinion	ACA Opinion	District Opinion	District Opinion
	(1)	(2)	(3)	(4)	(5)	(6)
Conservatism		8.17*** (1.23)		6.81*** (1.38)		7.01*** (1.40)
Republican (R=1)		1.12* (0.58)		1.58* (0.81)		1.51* (0.80)
Dem Pres Vote	-5.58*** (0.28)	-1.23*** (0.34)				
ACA Conservatism			2.67*** (0.46)	-0.74 (0.52)		
District Conservatism					1.60*** (0.34)	-1.04* (0.54)
Constant	1.15*** (0.23)	2.30*** (0.47)	0.73** (0.30)	1.54*** (0.38)	0.72*** (0.18)	1.62*** (0.40)
PCP	87.3	95.8	72.4	93.3	68.6	93.1
PRE	59.5	86.5	57.4	89.7	51.5	89.4
ePCP	79.6	93.2	61.6	89.7	58.9	89.8
AUC	91.3	98.9	74.2	97.8	69.5	97.8
Observations	1,912	1,910	525	525	525	525
Log Likelihood	-672.43	-262.21	-313.12	-102.19	-323.44	-101.32
Akaike Inf. Crit.	1,350.85	538.42	632.24	218.38	652.89	216.63
Bayesian Inf. Crit.	1,367.52	577.30	645.04	248.23	665.68	246.48

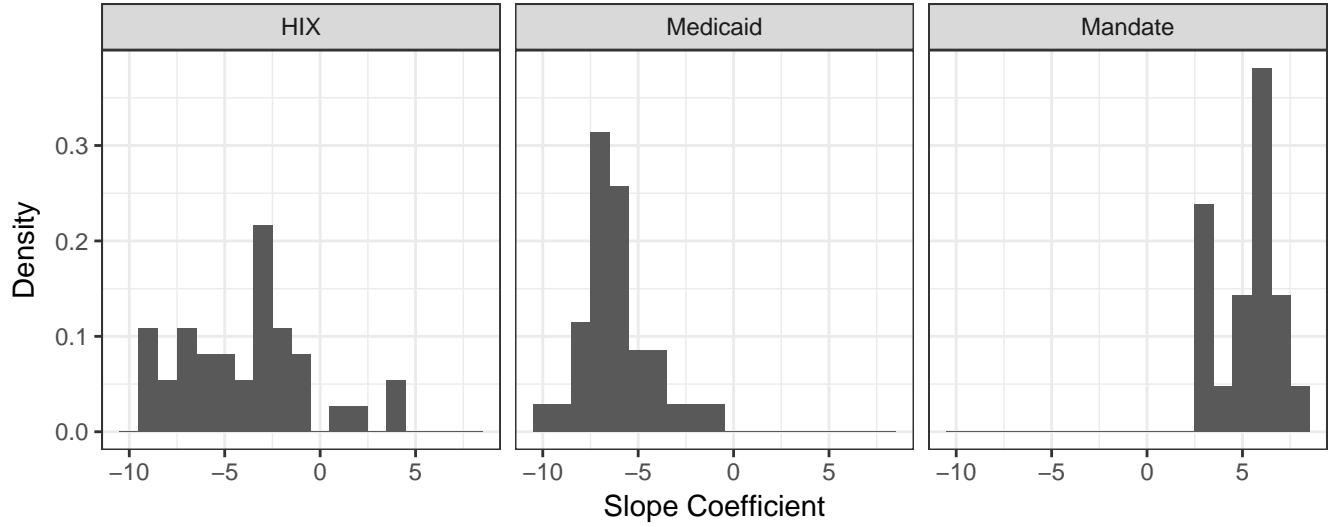
Note:

\*p<0.1; \*\*p<0.05; \*\*\*p<0.01

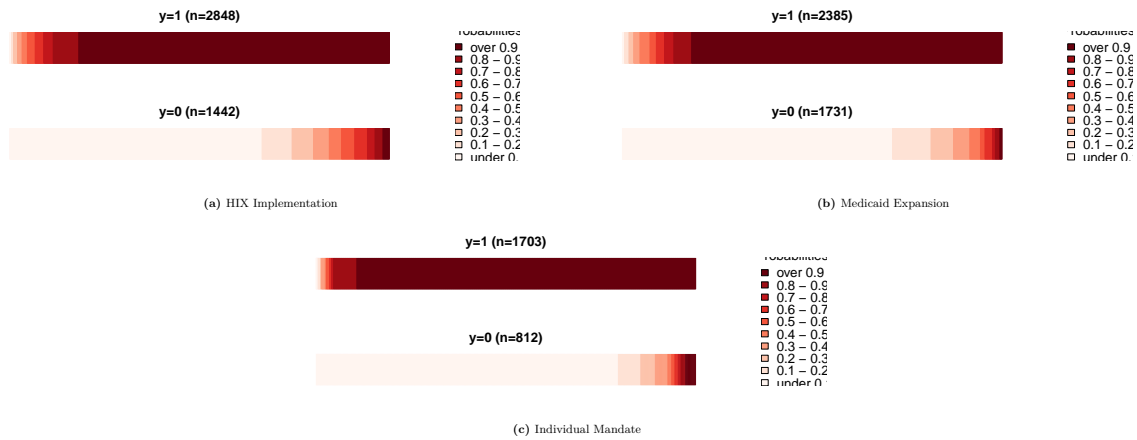




**Figure 1:** Predicted probability plots for select ACA implementation bills; top row is HIX bills, middle row Medicaid expansion, and bottom row mandate prohibition.



**Figure 2:** *Varying slope coefficients, by vote subset. Slopes differ by varying amounts across issue areas.*



**Figure 3:** *Separation plots of model fit for all subsets of votes. The models fit the data very well.*

## 5 Conclusion

This paper provides evidence that individual state legislator decisions in voting on health care exchange implementation, Medicaid expansion, and the individual mandate are highly ideologically charged. Legislator partisanship is an important predictor of votes, but that is largely because party and ideology are highly correlated in the modern era of polarized politics. Controlling for ideology, partisanship shrinks dramatically in importance. The power of ideology is masked by the ideological polarization in American state legislatures; yet, even with the limited intraparty ideological heterogeneity, we can see plenty of examples of moderate Republicans voting in favor of particular ACA exchange implementation and Medicaid expansion bills (but almost never in favor of the individual mandate). District opinion has an even more limited effect on legislator votes on these bills. True, districts that disapprove of the ACA tend to elect representatives that are also ill-inclined towards the law. Yet when push comes to shove, these legislators act as trustees, not agents, of the districts that elected them.

More broadly, other studies are needed to replicate and contextualize the findings of this paper regarding the absolutely primary role for ideology in legislator behavior. Variations in salience can, for example, show us whether party considerations might matter more when decisions are less publicly visible. While the high salience of Obamacare should support a strong role for public opinion, perhaps critical variation in the media environment has been missed. Do legislators in statehouses and/or districts with an active media presence from local newspapers and TV states act differently from those in states and districts with an atrophied media presence?

From a policy perspective, despite the fact that much of state level ACA implementation is occurring in the context of “red” states, this study shows that coalitions to pass concrete and important pillars of the Affordable Care Act are absolutely possible, but differ by state. In “blue” states where conservatives have little influence, these coalitions need merely be the entire Democratic caucus. In “red” states, this coalition can include sufficient numbers of moderate Republicans to pass whatever majority thresholds exist. Arkansas’ Medicaid expansion is a banner example of exactly this phenomenon. Arkansas Republicans are amongst the most conservative in the country, yet a majority of Republicans joined all state Democrats to pass expansion despite a 3/4 supermajority requirement. The most conservative Republicans in the state still voted no; but their votes were not required for passage. With regards to Medicaid expansion, Republican governors have been able to win over conservative legislatures with sufficiently accommodative waivers from the Obama administration. Moving forward, it looks like even more radical waivers may be necessary to get sufficient numbers of Republican votes to expand Medicaid in the remaining states. Whether

the Trump administration grants these waivers or does away with the program as a whole remains to be seen.

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