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The Politics of Healthcare Quality

A dissertation presented

by

Kirstin Woody Scott

to

The Committee on Higher Degrees in Health Policy

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

in the subject of

Health Policy

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Dissertation Advisor: Professor Robert Blendon Kirstin Woody Scott

The Politics of Healthcare Quality

Abstract

Improving the quality of care provided by the U.S. healthcare system is an important societal goal. Policymakers who wish to operationalize this goal must navigate an increasingly polarized health policymaking environment. In this dissertation, I examine three stakeholders who can influence this environment: the public, state governors, and health care providers. In Chapter 1, I explore attitudes of and experiences with health care quality among Democrats and Republicans. Relying on a national survey of 1,508 American adults, I find that regardless of having a recent medical issue, Democrats express greater concerns about national quality of care problems relative to Republicans. At the same time, I find no difference in their personal experiences with quality of care received while hospitalized or with healthcare providers. In Chapter 2, I examine how gubernatorial candidates treat health policy in the 2012 and 2014 elections given the states' increasing role in ACA implementation, which can collectively impact the quality of care provided nationally. After generating a novel database of all gubernatorial candidates' campaign websites, I summarize the presence of healthcare content, framing of health system problems, and issue engagement with the ACA and its key coverage provisions in these two elections. I find the majority of gubernatorial candidates discuss health policy but are selective in their focus. Republicans, who are more likely than Democrats to express their views specifically regarding the ACA (which they nearly all refer to as "Obamacare"), won the majority of these 47 gubernatorial seats. Winning candidates from both parties discussed the

Medicaid expansion decision of their state, with some expressing intentions to reverse course relative to their current expansion status. In Chapter 3, I examine a trend expected to grow under the ACA: hospital-physician integration. Using national hospital and Medicare data from 2003-2012, I document the rise of hospital employment of physicians and examine whether or not this yields improvements in mortality, readmission rates, length of stay or patient satisfaction. Though I find that a plurality of hospitals now enter into employment relationships with physicians, this study provides no evidence that these changes are associated with improvements in quality of care.

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For the many other individuals who deserve to be named here but I am not able to do so, please know how thankful I am for your support and accompaniment. For those who take time to read a portion or all of these pages, I hope you will find it instructive for your purposes and encourage you to continue learning tools that will help us better navigate the political realities influencing healthcare so that we can do even more to improve the system for others. The world needs it, and I am excited to be a part of this quest alongside you.

Chapter 1

Sick of Health Care Politics?*

**Components of this chapter have been submitted for publication (co-authors: Blendon and Benson). Please do not circulate.*

1.1. INTRODUCTION

Since the release of two seminal reports by the Institute of Medicine over a decade ago – *To Err is Human* and *Crossing the Quality Chasm* – there has been a growing body of literature to document persistent quality deficiencies in the nation's $2.9 trillion U.S. health care system.[1] This has helped to generate broad consensus among health policy experts about the need to improve the quality of care delivered by the U.S. healthcare system. Yet, the implementation of initiatives designed to improve quality of care can be constrained by a polarized political environment, which is influenced by public opinion.[2–5] Health policymaking in the U.S. has entered such an environment since the passage of the Affordable Care Act (ACA) in 2010.[6]

Though rising health care costs are more salient issues to the public, public opinion surveys have shown that the majority of Americans express concern with the state of the quality of healthcare nationally.[2,7–9] At the same time, however, Americans are generally highly satisfied with the quality of care they personally receive.[2,7] Relevant to the current political climate and politically polarized nature of health policymaking, it is curious that these views towards quality appear to differ by political party. In general, Democrats are more pessimistic about the quality of care in the country relative to Republicans. For example, a 2008 study showed that 41% of Democrats were very worried about the quality of care they receive relative to only 20% of Republicans.[10] Moreover, when asked about the honesty and ethical standards of medical doctors, 51% of Republicans rated them highly while only 34% of Democrats did so.[11]

A number of studies have examined Americans' perceptions of health care quality, especially regarding medical errors, but reasons for these partisan differences in attitudes towards quality of

care are not well known.[12,13] They could potentially stem from symbolic attitudes (such as party affiliation) based on the landscape of healthcare politics at the time or differential experiences with quality care (or some other indicator of "self interest").[10,13–15] A deeper understanding of these aggregate partisan differences in views on quality of care may help inform current efforts to improve quality in the current policymaking environment. This may be especially true given findings from a recent survey showing sizable differences between Republicans and Democrats in their views regarding how the ACA will affect quality of care, both nationally and personally (**Tables 1.1, 1.2**).[16,17]

Table 1.1. Perceptions of health reform law on quality of care, national impact. Question: "Under the health reform law, do you think the quality of health care *in the nation* will get better, worse or stay about the same?"

	Total (%)	Democrat (%)	Independent (%)	Republican (%)
Get Better	24	39	18	5
Get Worse	45	25	55	73
Stay About The Same	26	34	22	17

Note: Source of these data come from the Kaiser Family Foundation Health Tracking Poll, March 2013.[17]

Table 1.2. Perceptions of health reform law on quality of care, personal impact. Question: "Under the health reform law, do you think the quality of health care *of your own health care* will get better, worse or stay about the same?"

	Total (%)	Democrat (%)	Independent (%)	Republican (%)
Get Better	15	25	11	6
Get Worse	34	16	39	54
Stay About The Same	48	55	48	35

Note: Source of these data come from the Kaiser Family Foundation Health Tracking Poll, March 2013.[17]

To explore this phenomenon, I use data from a national survey of 1,508 respondents that allows for the unique opportunity to compare public opinion on quality of care not only between Republicans and Democrats but also in terms of whether or not they recently interacted with the healthcare system due to an illness. First, I examine if there are differences in how "healthy" and

“sick” partisans perceive the overall state of health care quality and the problems that may contribute to quality of care deficiencies. Second, I examine whether or not reported experiences with the health care system differ among sick partisans.

1.2. METHODS

Survey Data

This study relies on a 2012 survey titled “Sick in America”, conducted by National Public Radio, Robert Wood Johnson Foundation, and the Harvard School of Public Health.[18] This survey assessed Americans’ perceptions of and experiences with health care costs and quality in 2012, with an emphasis on the viewpoints of individuals who had been recently hospitalized or had regular contact with the healthcare system due to an illness or disability. Interviews were completed via telephone (including both landline and cell phone) in English or Spanish by Social Science Research Solutions (SSRS) between March 5-25, 2012, among a nationally representative sample of randomly selected adults (ages 18 and above) residing in the United States.

The total number of survey respondents was 1,508 (margin of error (MOE) ± 3.1). Using the fourth calculation of the American Association for Public Opinion Research (AAPOR) response and cooperation rate, the overall rates were 22.2% and 39%, respectively.[19] While the response rate is lower than those of government surveys, it is similar to other nationally-representative surveys that assess social and political trends (e.g., the Gallup and Pew polls) and also rely on a random digit dialing (RDD) of landline and cell phone users.[20,21] Moreover, a number of studies

have shown little evidence of an association between nonresponse bias and response rates in RDD surveys.[22]

Survey Questions & Context

The “Sick in America” survey contained sections on various dimensions regarding health care costs and quality, the latter of which is the focus of this chapter. This poll was done in parallel with a survey titled “Sick in Massachusetts” among a representative sample of adults in the state of Massachusetts, which passed its own health reform law in 2006. Results from the cost dimensions of the questionnaire, comparisons with the parallel Massachusetts survey, as well as substantive differences between sick and healthy Americans have been described elsewhere.[23,24]

Variables

Independent Grouping Variables

Using demographic data from the survey – including party affiliation and whether or not someone had a recent interaction with the healthcare system due to an illness – I generated four key independent grouping variables of interest in this study:

- Group 1: Recent Interaction with Healthcare System (Sick vs. Healthy);
- Group 2: Party Affiliation (Republican vs. Democrat);
- Group 3: Healthy Partisans (Healthy Republicans vs. Healthy Democrats); and
- Group 4: Sick Partisans (Sick Republicans vs. Sick Democrats).

Group 1: Recent Interaction with Healthcare System (Sick vs. Healthy)

For the ease of reporting, respondents were categorized as being "sick" if they responded yes to either of the following two survey questions: 1) did they have "a serious illness, medical condition, injury or disability requiring a lot of medical care in the past 12 months" or 2) had they been "hospitalized overnight in the past 12 months." The remaining respondents who answered no to these questions were coded as "healthy". This dichotomous variable (*sick*) took the value of 1 if the respondent met these criteria and 0 if they did not; it served as my proxy for whether or not someone had a recent, personal interaction with the health care system. Only a minority of respondents (11 of 1508 in the unweighted sample - see section below for explanation of weighting) had missing values for this category and were excluded from the analysis (**Table 1.3**). A total of 516 of the 1,508 respondents (MOE ± 7.2) met these criteria in the unweighted sample, translating into a total of 28% percent of respondents in the weighted sample.

Table 1.3. Number of Sick Respondents in Analysis (unweighted and weighted)

Sick Respondent (code)	Frequency (unweighted)	Frequency (weighted)
Yes (1)	516	411
No (0)	981	1084
Missing (.)	11	13
Total	1508	1508

It was also possible to distinguish the subset of the sick respondents that reported being hospitalized. This was a dichotomous variable taking the value of 1 if the respondent had been hospitalized (unweighted: n=291, weighted: n=214) and 0 if they had not reported being hospitalized in the past 12 months. This was the subgroup analyzed for those questions asked only among hospitalized respondents.

Group 2: Party Affiliation (Republican vs. Democrat)

Respondents were first asked, "Generally speaking, do you usually think of yourself as a Republican, a Democrat, or an Independent?" If respondents answered Republican or Democrat, they were coded as such. Respondents who answered "Independent" or voluntarily offered another response (e.g., other party, don't know, refused) were then asked this follow up question: "As of today do you lean more to the Democratic Party or the Republican Party?" I summarize the spectrum of responses in **Table 1.4.**

Table 1.4. Number and Percentage of Respondents by Political Party Affiliation, Full Spectrum *(Unweighted & Weighted)*

	Rep.	*Lean Rep.*	*Ind.*	*Lean Dem.*	*Dem.*	*Other/No Affiliation*	*DK/Refused*
Unweighted Count	318	163	183	201	526	60	57
Unweighted (%)	21	11	12	13	35	4	4
Weighted Count	288	174	226	219	475	69	58
Weighted (%)	19	12	15	15	31	5	4

Note: Rows may not add to 100 percent due to rounding. Rep=Republican; Ind=Independent; Dem=Democrat; DK=Don't Know.

Based on evidence that political behavior between party identifiers and leaners are similar, I grouped Republicans with "lean Republicans" and Democrats with "lean Democrats" in the analytical sample, as was done with other studies using the "Sick in America" survey.[23,25] I refer to these groups as simply Republicans and Democrats, respectively, and dummy coded as such (*republican*=1 (Republican); *republican*=0 (Democrat); *republican*=(.) (Independent/Other/Unknown)).

Groups 3 and 4: Healthy and Sick Partisans

The key variable of interest in this study is the combination of political party affiliation and self-reported illness experience, the latter of which indicated whether or not the respondent was recently hospitalized or had frequent interactions with the healthcare system. I thus combined these two grouping variables related to illness experience and party affiliation to generate the subgroups of interest in this study: healthy partisans (healthy Democrat, healthy Republican) and sick partisans (sick Democrat, sick Republican). In **Table 1.5**, I summarize the unweighted and weighted counts of these combinations. The proportion of sick respondents was comparable across the two political parties (30% of Democrats versus 26% of Republicans, p=0.21).

Table 1.5. Number of Sick Respondents by Political Party+Leaner Affiliation *(Unweighted & Weighted)*

	Sick		*Healthy*	
	Republican	Democrat	Republican	Democrat
Unweighted Count	145	281	336	440
Unweighted Percentage (%) (column by party)	30%	39%	70%	61%
Weighted Count	121	206	341	481
Weighted Percentage (column by party)	30%	26%	70%	74%

Note: Rows within the sick and healthy groups will not add to 100 percent as a proportion of the respondents who were Independent or Other political party affiliation were also sick. However, the cells will add to 100 percent when examining sick versus healthy in the same political party (e.g., 30% sick Republicans vs. 70% healthy Republicans).

Dependent Variables

I generated a range of dichotomous outcome variables that fall into four main groups: 1) perceptions of national quality issues (e.g., state of healthcare quality, reasons for quality problems), 2) attitudes about doctors, and 3) satisfaction with hospital and medical care, and 4) reported experiences with health care quality (in hospitals and general medical care). The first

two were asked of both healthy and sick respondents, while the latter two were asked only of hospitalized and/or sick respondents. Depending on the question type, I dichotomized responses into sensible groupings, such as combining “very satisfied” with “somewhat satisfied” and “major problem” versus “minor problem or not a problem”.

Statistical Analysis

To complete this analysis, I first applied sampling weights to the data to account for design effects and socioeconomic differences in nonresponse rates, adjusting to meet 2011 U.S. Current Population Survey (CPS) parameters for age, sex, region, race or ethnic group, level of education, telephone status, and region. All analyses rely on these weighted data that reflect the actual composition of the general population.

To account for survey weighting and produce accurate population standard error estimates when conducting subpopulation analyses (e.g., to compare healthy and sick Republicans and Democrats, only), I created a number of analytical subpopulations. First, I created a subpopulation denoting all partisans, which was coded as 1 if an individual was either Republican or Democrat (republican=0 or 1). For all Independents or Other Affiliation respondents, they were coded as 0, but not missing in this subpopulation. Similarly, I created a subpopulation of sick partisans (coded as 1 if the respondents were both sick and Republican or sick and Democrat, and 0 for all others). Lastly, I created the subpopulation of healthy partisans (coded as 1 if the respondents were both healthy and Republican or healthy and Democrat, and 0 for all others). The only individuals coded as “missing” in the subpopulations were the

respondents who reported Don't Know for both sickness status (n=11 respondents) and political party affiliation; therefore, these few respondents were excluded from the analysis.

To summarize subgroup responses to each outcome variables, I conducted a series of survey-weighted cross-tabulations using the Rao-Scott adjustment to the Pearson χ^2 test to account for survey weighting and test for statistical differences between the groups. I denote in the following tables the question types for which the full eligible sample was not asked a particular question.

Though the primary focus is to examine aggregate polling outcomes by the political parties – stratified by the proxy for having a recent interaction with the healthcare system – I also conducted a series of analyses to account for potential confounding variables to see if differences in the predicted responses for each group persist in the adjusted models.

I therefore estimated a series of weighted multivariate logistic regression models to yield adjusted predictive margins of the binary categorical outcomes for all subgroups. All multivariate logistic models took into account the following covariates: gender (male/female), age (under 65/65 or older), insurance status (insured/uninsured), minority status (minority/not a minority), employment (full or part time/not employed), education (college education and above/high school and below), region (Northeast, North Central, South, West), and household income level (<50,000, 50,000+).[26,27]

After estimating each model, I calculated the predictive margins of responding to each outcome of interest with linearized standard errors (*vce, unconditional*) and tested the difference between the subgroup. Further, to determine whether or not sickness modifies quality of care views of Republicans and Democrats differently, I estimated a series of logistic regression models that included an interaction term (*republican*sick*) both with and without covariates.

Given that the results of the adjusted models did not differ substantively from the unadjusted models, I primarily report the unadjusted weighted cross-tabulation results for all outcomes for ease of interpretation. For comparison, however, I also provide the adjusted predictive margins for the outcomes explored in this study.

All analyses were completed using Stata 13.0, relying on commands that account for survey weighting (e.g., *svy:, subpop*). The Institutional Review Board at the Harvard T.H. Chan School of Public Health determined that this study is not human subjects research.

1.3. RESULTS

Assessment of quality as a problem for the country

When asked about their general assessment of the current state of health care quality in the U.S., approximately 6 in 10 of all respondents (60%) expressed that quality of care is a very or somewhat serious problem for the country.

When examining these views by illness experience and party affiliation, those who were sick (relative to healthy) and those who were Democrats (relative to Republicans) were more likely to

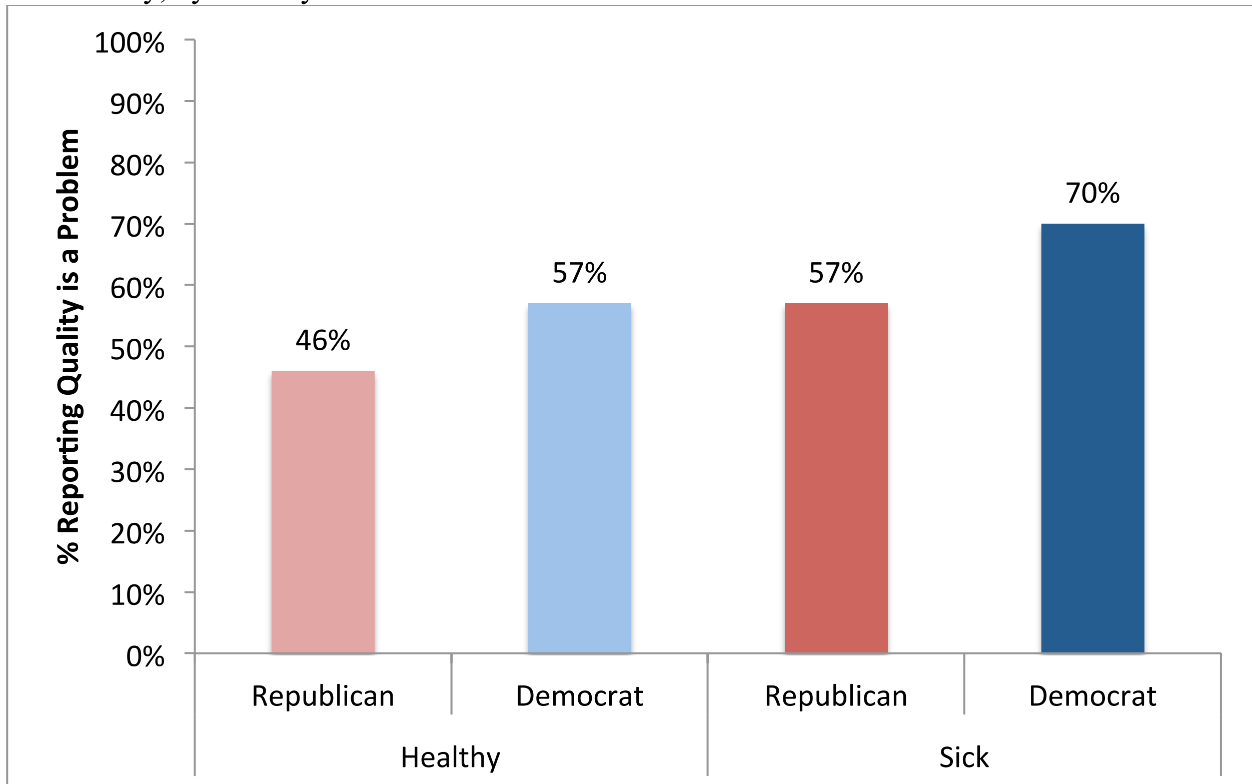
express that quality is a problem (**Table 1.6**). Among healthy partisans, Democrats are slightly more concerned with the state of health care quality in the nation (57%) relative to 46% of Republicans (p=0.02). These differences persisted among sick partisans, with sick Democrats (70%) being more concerned about quality of care relative to sick Republicans (57%) ($p<0.01$) **(Figure 1.1)**. This general pattern remained, though the differences were no longer statistically significant in the adjusted model.

Table 1.6. Percent Reporting that Quality of Care is a Somewhat or Very Serious Problem for the Country, by Illness Experience, Party & Combination *(Unadjusted & Adjusted Results)*

		Unadjusted		**Adjusted^**	
Group	Subgroup	% Respond	*p-value*	% Respond	*p-value*
Illness	Healthy	54%	0.001	55%	0.020
	Sick	66%		63%	
Party	Republican	49%	0.000	51%	0.029
	Democrat	61%		60%	
Healthy	Republican	46%	0.011	49%	0.193
	Democrat	57%		55%	
Sick	Republican	57%	0.022	58%	0.087
	Democrat	70%		69%	

Note: ^These are predictive margins of the probability of responding that quality of care is a problem for both Republicans and Democrats in each subgroup, using the margins with linearized standard error (vce, unconditional) specification following estimating the logit model that includes covariates for: age, gender, insurance status, employment status, minority status, education, region, and income.

Figure 1.1. Percent Reporting that Quality of Care is a Somewhat or Very Serious Problem for the Country, by Healthy Partisans and Sick Partisans



Note: Difference between healthy Republican and healthy Democrats as well as between sick Republicans and sick Democrats are statistically significant ($p<0.05$) in unadjusted model. In the adjusted model, these differences narrow slightly and are no longer statistically significant at this level.

Reasons for Quality of Care Problems in the Country

To assess respondents' views of potential contributors to problems in healthcare quality in the country today, they were presented items from a list of eighteen questions – such as "concerns about inadequate training of health care professionals" – and asked if they believed that the issue was a major, minor or not a reason for problems with healthcare quality in the country today. In **Table 1.7**, I summarize the percentage of respondents in each group of interest *(sick versus healthy, Republican versus Democrat)* reporting that a given item was a "major reason" for quality of care problems in the country. I list the 18 items in the order that corresponds with the percentage of sick respondents that reported each issue as a major reason for quality of care

problems (as opposed to minor reason, not a reason at all or don't know/refused). Similarly, in **Table 1.8**, I show the results for the key groups of interest in this chapter: healthy versus sick partisans. I provide the unadjusted results for both, but denote when the predicted difference was no longer statistically significant in the adjusted model.

The issues most commonly considered "major" reasons for quality of care problems in the country were nearly identical across all four subgroups, with the top being "some people not being able to afford to get the tests or drugs they need". In general, sick respondents – regardless of party affiliation - appear to consistently rate each of the 18 items as a "major" reason for quality of care problems nationally more often relative to their healthy counterparts across all measures. However, statistical differences were detected between sick and healthy respondents for only 4 of the 18 items (3 of which were no longer significant in the adjusted model). The largest absolute difference emerging between healthy and sick Americans when asked if "many people not being able to get access to the high-quality doctors and hospitals that exist" was a major reason for quality problems; approximately, 74% of sick Americans reported that this was a major reason for quality of care problems whereas only 56% of healthy Americans did so ($p<0.001$).

Unlike the comparison between sick and healthy respondents, there were a number of sizable differences detected across the majority of the 18 items between Democrat and Republican responses. In general, Democrats were more likely to report each issue as a "major reason" for quality of care problems, and these aggregate partisan differences were statistically significant among 12 of the 18 items.

Table 1.7. Percentage of respondents reporting that item is a "major" reason for quality of care problems in the country, by illness status (among all respondents, sick versus healthy) and by political party (Republicans and Democrats)

	Illness Experience				Party Rank		Party			
Reason for Quality of Care Problems	Sick	Healthy	Gap (S-H)	P Value	Dem	Rep	Dem	Rep	Gap (D-R)	P Value
Some people not being able to afford to get the tests or drugs they need	78%	79%	0%	0.966	1	1	86%	65%	**21%**	0.000
Many people not being able to get access to the high-quality doctors and hospitals that exist	74%	56%	**18%**	<0.001	2	5	73%	45%	**28%**	0.000
The influence of health insurance plans on treatment decisions	70%	62%	8%	0.134	3	3	69%	55%	**14%**	0.016
People not getting the drugs or tests they need	63%	50%	**13%**	0.027^	4	6	59%	44%	**15%**	0.013
People getting too many tests or drugs that they don't need	58%	48%	11%	0.063	5	4	53%	49%	4%	0.535
Doctors or nurses not spending enough time with patients	53%	45%	8%	0.167	9	7	48%	43%	5%	0.443
People not following the advice or treatment recommendations of their doctors	52%	42%	10%	0.074	6	9	50%	36%	**14%**	0.020^
Health professionals not working together or not communicating as a team	50%	41%	9%	0.140	7	10	50%	31%	**19%**	0.001
Healthcare professionals not giving appropriate recommendations since they don't understand the culture/background of their patients	46%	30%	**15%**	0.008^	12	11	38%	29%	9%	0.121
Overwork, stress or fatigue of health professionals	44%	46%	-2%	0.670	8	8	48%	41%	7%	0.249
Excessive government regulation of doctors and hospitals	43%	42%	1%	0.840	15	2	29%	58%	**-29%**	0.000
Patients not being sent to the right kind of doctor	43%	33%	9%	0.095	10	14	42%	25%	**17%**	0.005^
Not enough doctors or nurses in hospitals or medical offices	40%	32%	7%	0.159	11	12	40%	27%	**13%**	0.028^
Many hospitals not having the latest medical technology	38%	27%	11%	0.047	13	15	31%	24%	7%	0.196
Doctors/nurses not giving clear instructions about treatment advice	36%	25%	**11%**	0.033^	14	16	31%	19%	**12%**	0.030^
Discrimination against patients because of their race/ethnicity	32%	21%	10%	0.051	16	17	27%	14%	**13%**	0.007^
Inadequate training of health professionals	31%	26%	5%	0.341	16	13	27%	26%	1%	0.850
Lack of computerized medical records	27%	20%	7%	0.150	16	17	27%	14%	**13%**	0.009^

Note: S=Sick, H=Healthy; D=Democrat; R=Republican; Each item was asked of 1/3rd of the sample. These are column percentages, with remainder of respondents saying that issue was a minor reason, not a reason, or Don't Know/Refused. Items are ranked by top issues among all sick respondents in the survey, regardless of political party affiliation. Bolded text denotes those differences (gaps) that are statistically significant in the unadjusted model. ^Indicates that difference is no longer statistically significant in adjusted logit model that accounts for age, gender, insurance status, employment status, minority status, education, region, and income.

Table 1.8. Percentage of respondents reporting that item is a "major" reason for quality of care problems in the country, by sick partisans and healthy partisans

	Healthy Partisans				Sick Partisans			
Reason for Quality of Care Problems	*Healthy Dem*	*Healthy Rep*	*Healthy Gap (D-R)*	*P Value*	*Sick Dem*	*Sick Rep*	*Sick Gap (D-R)*	*P Value*
Some people not being able to afford to get the tests or drugs they need	86%	67%	**20%**	0.001	86%	58%	**28%**	0.002
Many people not being able to get access to the high-quality doctors and hospitals that exist	67%	43%	**24%**	0.002	86%	52%	**34%**	0.000
The influence of health insurance plans on treatment decisions	66%	54%	12%	0.099	75%	57%	17%	0.069
People not getting the drugs or tests they need	57%	38%	**19%**	0.011	67%	59%	8%	0.421
People getting too many tests or drugs that they don't need	49%	49%	0%	0.985	65%	49%	15%	0.136
Doctors or nurses not spending enough time with patients	44%	44%	0%	0.985	56%	41%	15%	0.150
People not following the advice or treatment recommendations of their doctors	45%	36%	10%	0.195	64%	36%	**28%**	0.005
Health professionals not working together or not communicating as a team	49%	33%	**16%**	0.029^	53%	24%	**29%**	0.004
Healthcare professionals not giving appropriate recommendations since they don't understand the culture/background of their patients	31%	23%	8%	0.268	53%	41%	13%	0.234
Overwork, stress or fatigue of health professionals	47%	45%	2%	0.824	52%	32%	**20%**	0.044^
Excessive government regulation of doctors and hospitals	25%	66%	**-41%**	0.000	39%	39%	<1%	0.949
Patients not being sent to the right kind of doctor	36%	24%	12%	0.096	52%	28%	**24%**	0.024^
Not enough doctors or nurses in hospitals or medical offices	38%	25%	13%	0.061	42%	35%	8%	0.425
Many hospitals not having the latest medical technology	29%	23%	5%	0.430	35%	25%	10%	0.265
Doctors/nurses not giving clear instructions about treatment advice	28%	18%	10%	0.131	39%	21%	18%	0.053
Discrimination against patients because of their race/ethnicity	24%	12%	**13%**	0.024^	32%	20%	12%	0.203
Inadequate training of health professionals	24%	27%	-3%	0.685	32%	22%	10%	0.272
Lack of computerized medical records	25%	12%	**13%**	0.024^	34%	20%	14%	0.147

Note: S=Sick, H=Healthy; D=Democrat; R=Republican; Each item was asked of 1/3rd of the sample. These are column percentages, with remainder of respondents saying that issue was a minor reason, not a reason, or Don't Know/Refused. Items are ranked by top issues among all sick respondents in the survey, regardless of political party affiliation. Bolded text denotes those differences (gaps) that are statistically significant in the unadjusted model. ^Indicates that difference is no longer statistically significant in adjusted logit model that accounts for age, gender, insurance status, employment status, minority status, education, region, and income.

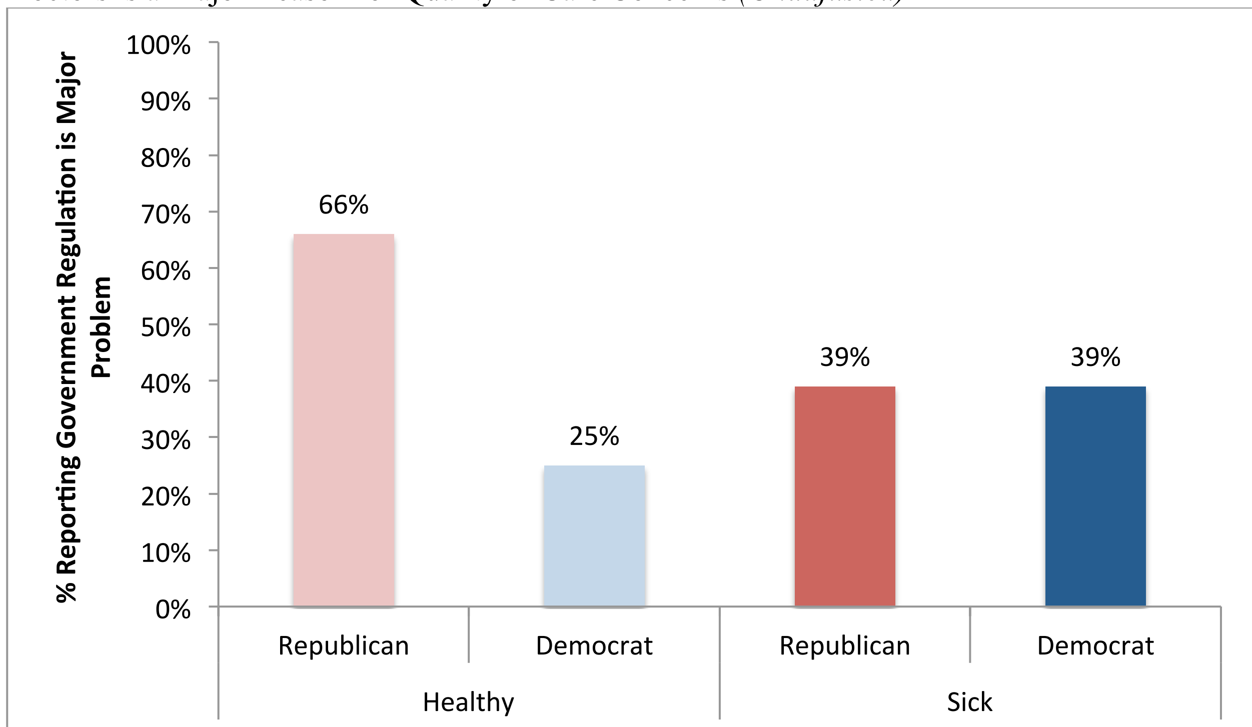
Given these aggregate group differences by political party, I examined if these differences persisted among healthy and sick partisans. I found that among sick and healthy partisans, they similarly reported that "people not being able to afford the tests or drugs that the need" as well as "the influence of health insurance plans on treatment decisions" were major reasons for quality problems. The degree to which each of these items are "major" problems, however, was consistently higher among Democrats – regardless of being sick or healthy – relative to Republicans. This was especially apparent for issues relating to affordability and access, regardless of whether or not they recently interacted with the healthcare system.

Among the 5 items where statistically significant differences emerged between healthy Republicans and healthy Democrats, I found that the partisan gap for the same questions was larger among sick partisans. For instance, when asked if "many people not being able to get access to the high-quality doctors and hospitals that exist" is a major reason for quality of care problems, 67% of healthy Democrats versus 43% of healthy Republicans agreed (difference of 23 percentage points, $p<0.001$) whereas 86% of sick Democrats and 52% of sick Republicans reported so (difference of 34 percentage points, $p<0.001$). Attitudes towards two other items ("patients not being sent to the right doctor," and "people not following the advice or treatment recommendations of their doctors") were not significantly different among healthy partisans, but differed by more than 20 percentage points among sick partisans.

A notable exception to this pattern of widening partisan gaps, however, were attitudes towards a question focused on government regulation. This was the only issue that was not reported as a major issue more often by Democrats relative to Republicans across all 18 items. Specifically,

66% of healthy Republicans reported “excessive government regulation of doctors and hospitals” as a major reason for quality of care problems nationally (indeed the second top issue for this group) whereas only 25% of healthy Democrats did so ($p<0.001$). When examining the views of sick partisans on this metric, however, this partisan difference essentially disappeared. Approximately 40% of sick respondents – regardless of party – reported this as a major problem **(Figure 1.2).** Sick Democrats appeared more concerned about excessive government regulation relative to their healthy counterparts whereas sick Republicans appeared less concerned about this issue than healthy Republicans. In a sensitivity analysis, the coefficient on the interaction term between sickness and party was significant for this measure in both unadjusted and adjusted models ($p<0.01$) (**Table 1.9**).

Figure 1.2. Percent Responding That Excessive Government Regulation of Hospitals and Doctors is a Major Reason for Quality of Care Concerns *(Unadjusted)*



Note: Difference between healthy Republican and healthy Democrats as well as between sick Republicans and sick Democrats are statistically significant ($p<0.05$) in both the unadjusted and adjusted models. There is no difference between sick Republicans and sick Democrats.

Table 1.9. A taxonomy of logistic regression models displaying the fitted relationship of responses to "excessive government regulation of doctors and hospitals" as a major reason for quality of care problems

	Model 1 Odds Ratio (95% CI)	Model 2 Odds Ratio (95% CI)	Model 3 Odds Ratio (95% CI)	Model 4 Odds Ratio (95% CI)	Model 5 Odds Ratio (95% CI)
Sick	0.889		0.87	1.905	2.038
	(0.54,1.47)		(0.50,1.53)	(0.97,3.73)	(1.00,4.17)
Republican		3.332***	3.321***	5.744***	6.696***
		(2.00,5.54)	(2.00,5.52)	(2.98,11.09)	(3.34,13.44)
Republican*Sick				0.169**	0.146***
				(0.06,0.49)	(0.05,0.43)
65 Years +					0.674
					(0.36,1.25)
Male					0.741
					(0.44,1.25)
Insured					2.154
					(0.81,5.73)
Employed					0.844
					(0.48,1.50)
Minority					1.186
					(0.60,2.35)
Some College or More					1.556
					(0.90,2.70)
Region *(Ref: Northeast)*					
North Central					1.752
					(0.86,3.56)
South					1.572
					(0.78,3.16)
West					0.947
					(0.41,2.18)
Constant	0.723*	0.416***	0.435***	0.341***	0.123**
	(0.54,0.97)	(0.30,0.58)	(0.30,0.63)	(0.22,0.52)	(0.03,0.47)
No. of Obs.*	401	402	401	401	396

Note: With the exception of region, all covariates are dummy coded. *Number of observations in the subpopulation of interest. The primary predictors republican (republican=1, democrat=0), sick (sick=1, healthy=0), their interaction (republican*sick) and covariates within the subpopulation of *allpartisans.*

Learning from the "Bottom Issues"

Relative to concerns of access and affordability, this issue of computerized medical records was not perceived by a majority of respondents as a "major reason" for quality of care problems. Relatively few respondents report that they think that the "lack of computerized medical records" is a "major problem" for health care quality, ranging from 12% among healthy Republicans to 34% among sick Democrats, when compared to the other items listed in Tables 1.7 and 1.8 above. This has implications for policymakers who may be prioritizing improvements in health information technology uptake as few American adults indicate this being a major reason for quality of care challenges nationally.

Attitudes About Doctors

Respondents were given the option of agreeing or disagreeing with a variety of positive statements regarding doctors, such as if physicians "explained things well to their patients." **Table 1.10** summarizes the percentage of Americans, in each subgroup, that agree with these positive statements. In general, sick Americans were more likely to agree with these positive statements relative to those who had not reported having a recent illness experience. When examining the parties in aggregate, I found that Republicans were more likely to agree with these positive statements relative to Democrats. This is consistent with the general pessimism I found among Democrats when examining their views on the state of quality of care and issues contributing to these problems relative to Republicans.

Table 1.10. Percentage Agreeing with Positive Statements Regarding Doctors, by Illness Experience, Party and Combination

	Illness Experience			**Party**			**Healthy Partisans**			**Sick Partisans**		
Percentage Agreeing with Positive Statement	*Sick*	*Healthy*	*P Value*	*Dem*	*Rep*	*P Value*	*Healthy Dem*	*Healthy Rep*	*P Value*	*Sick Dem*	*Sick Rep*	*P Value*
Doctors are usually up to date on the latest advances in medicine	70%	74%	0.190	73%	74%	0.843	74%	77%	0.333	73%	64%	0.114
Doctors usually explain things well to their patients	59%	66%	0.019	64%	66%	0.6392	66%	69%	0.493	61%	58%	0.572
Doctors are active in trying to hold down the cost of medical care	42%	34%	0.026	33%	39%	0.055	29%	38%	0.019	43%	41%	0.827
Doctors fees are usually reasonable	41%	42%	0.900	40%	47%	0.042^	38%	48%	0.024	43%	42%	0.952
Most doctors spend enough time with their patients	39%	39%	0.954	36%	44%	0.016	31%	47%	0.000	47%	37%	0.075

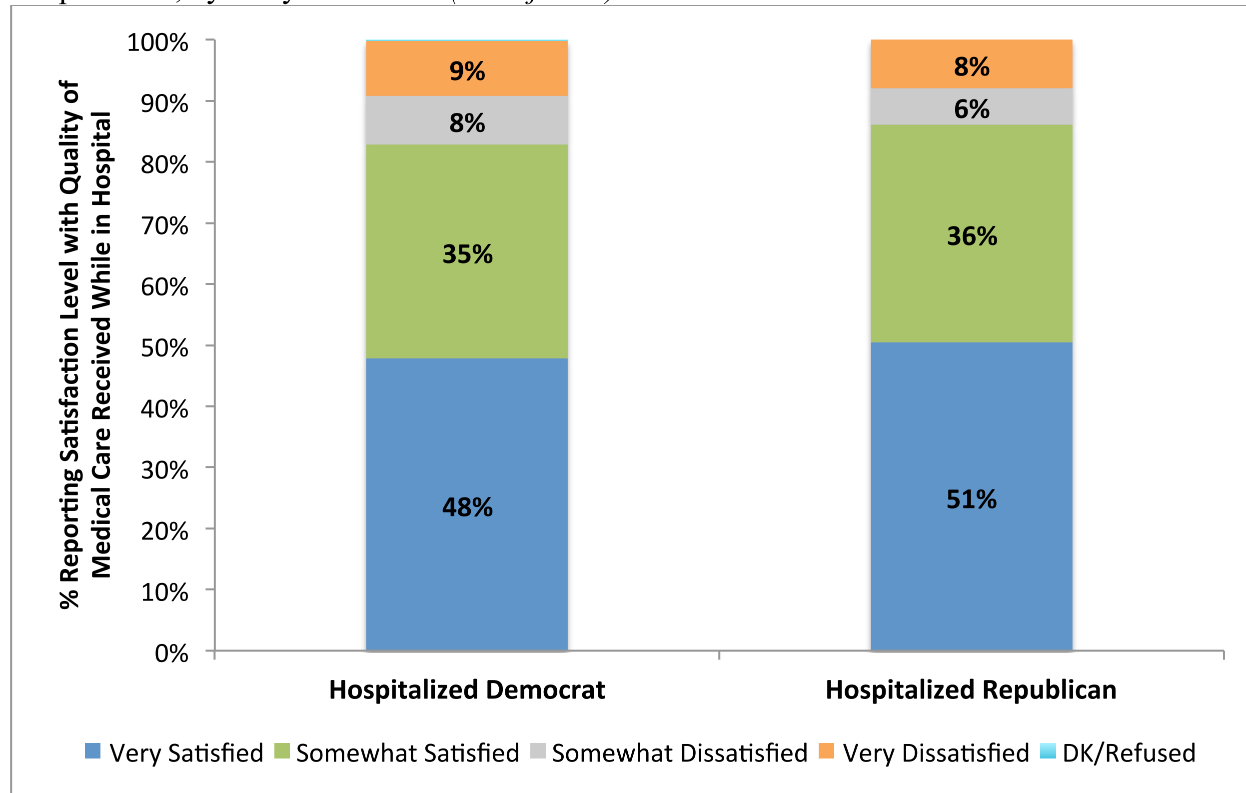
Note: ^Indicates that difference is no longer statistically significant in adjusted logit model that accounts for age, gender, insurance status, employment status, minority status, education, region, and income.

When comparing the views of healthy partisans versus sick partisans, I found an interesting trend that contrasted with the “widening gap” emerging between sick partisans relative to healthy partisans in the questions related to national quality of care problems. Specifically, healthy Republicans were more likely to agree with these positive statements relative to healthy Democrats **(Table 1.10).** For instance, nearly half (47%) of healthy Republicans said they agreed that most doctors spend enough time with patients whereas only 31% of healthy Democrats did so ($p<0.001$). In contrast, there were no significant differences detected between sick Democrats and sick Republicans on any of these measures.

Satisfaction with Quality of Care Received

Among the subgroup of respondents who reported being hospitalized in the last 12 months, I found that they were highly satisfied with the quality of care they received in the hospital. More than 80% of hospitalized Democrats and hospitalized Republicans were somewhat or very satisfied with the quality of their hospital care (**Figure 1.3; Table 1.11**).

Figure 1.3. Level of Satisfaction With Quality of Hospital Care Among Hospitalized Respondents, by Party Affiliation *(Unadjusted)*



Note: Design-based Pearson chi-square test for group differences: p-value 0.956.

Table 1.11. Percent of Hospitalized Respondents Reporting Being Somewhat or Very Satisfied with the Quality of Medical Care Received While in Hospital, by Political Party

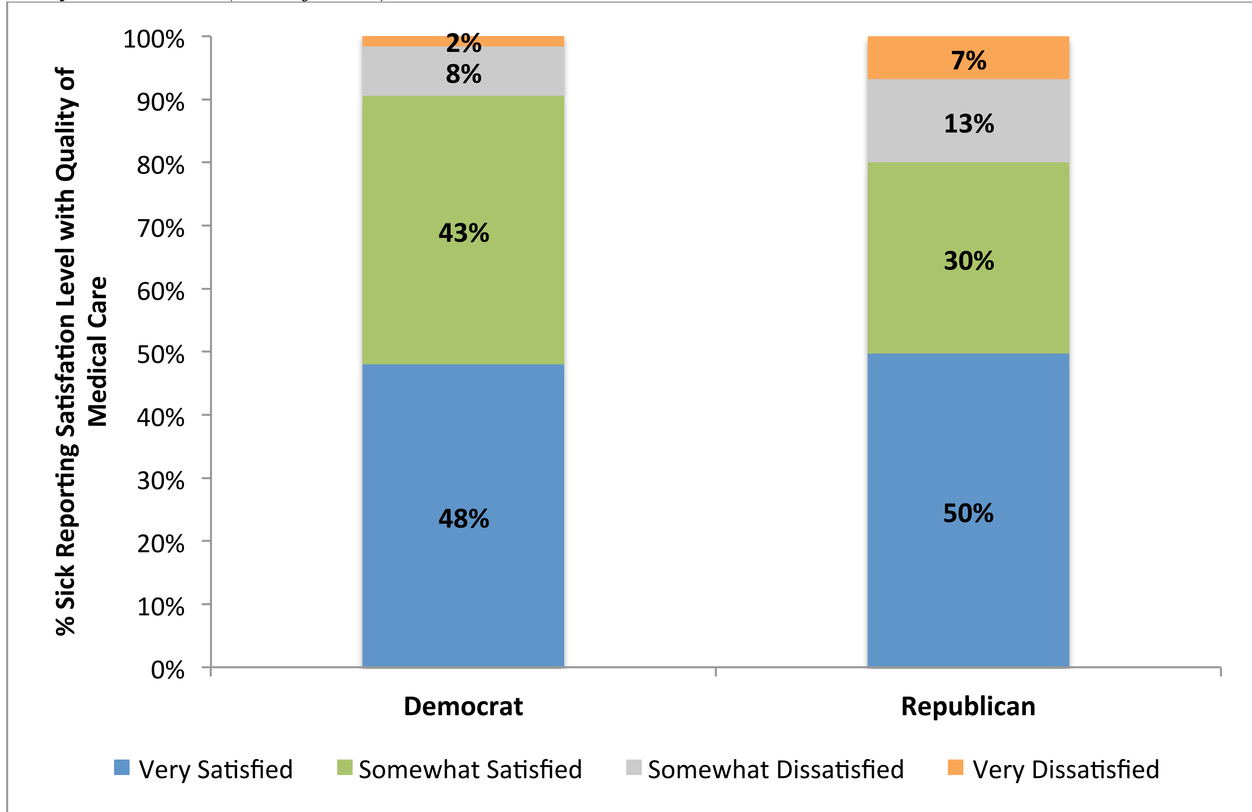
	Unadjusted			**Adjusted^**		
	Democrat	Republican	p-value	Democrat	Republican	p-value
Somewhat or Very Satisfied	83%	86%	0.635	83%	83%	0.990

Note: ^Adjusted logit model includes these covariates: age, gender, insurance status, employment status, minority status, education, region, and income. The remainder would be those who reported being somewhat or very dissatisfied with their care or the <1% who responded Don't Know to this question.

Similarly, the large majority of sick respondents were satisfied with their medical care that they had received in the last year. Nine in 10 sick Democrats reported being somewhat or very satisfied with the care they received, while 8 in 10 Republicans reported these positive impressions (p-value=0.03). After adjusting for age, gender, minority status, income and other covariates, however, these differences narrowed slightly and the difference was no longer

statistically significant (89% sick Democrats versus 82% of sick Republicans, p-value=0.52) **(Figure 1.4; Table 1.12)**.

Figure 1.4. Level of Satisfaction With Quality of Medical Care Among Sick Respondents, by Party Affiliation *(Unadjusted)*



Note: Design-based Pearson chi-square test for group differences: p-value 0.044.

Table 1.12. Satisfaction with Medical Care Quality Among Sick Respondents, By Political Party

	Unadjusted			**Adjusted^**		
	Democrat	Republican	p-value	Democrat	Republican	p-value
Somewhat or Very Satisfied	90%	80%	0.024	89%	82%	0.186

Note: ^Adjusted logit model includes these covariates: age, gender, insurance status, employment status, minority status, education, region, and income. The remainder would be those who reported being somewhat or very dissatisfied with their care.

Experiences with Hospitalizations

Among the respondents who reported having an "overnight stay in a hospital in the past 12 months", they were asked whether or not a series of twelve events – that would signal poor quality care – occurred during their hospital stay (**Table 1.13**).

A minority of respondents indicated that any of these events occurred, ranging from approximately 3 in 10 sick partisans that "nurses were not available" when needed to less than 1 in 10 reporting that nurses failed to check their name or allergies before giving them a treatment. Experiences with poor quality hospital events were comparable between sick Democrats and sick Republicans. The only exception for party differences among hospitalized respondents was that more Democrats expressed concerns about privacy (20%) relative to Republicans (7%); this difference remained after adjusting for potential confounders.

Table 1.13. Percentage of Hospitalized Respondents Indicating That Event Took Place During Their Hospital Stay, by Party *(Unadjusted)*

Poor Quality Event at Hospital	Dem	Rep	p-value
Nurses were not available when you needed them or did not respond quickly to requests for assistance	37%	30%	0.425
There was poor communication among the doctors, nurses and other health care professionals involved in your care	29%	32%	0.732
Doctors, nurses, and health care professionals did not communicate information about your condition or treatment clearly to you or a family member	25%	15%	0.177
Doctors were not available or did not respond quickly when you needed	20%	24%	0.623
You did not have enough privacy*	20%	8%	0.016
Doctors, nurses or other health care professionals did not wash hands or use hand sanitizer every time before entering the room or examining you	20%	14%	0.330
Your room was not clean enough	18%	17%	0.877
The doctors and nurses did not give you the information you needed about your care after leaving the hospital	18%	17%	0.969
You believe you were given the wrong diagnosis, treatment or test	9%	13%	0.471
You were treated poorly because of your race, ethnicity, cultural background or language	8%	7%	0.863
You got an infection while in the hospital	6%	13%	0.150
Nurses did not check your name or allergies before giving you treatment	6%	8%	0.568

Note: Dem = Democrat; Rep=Republican; ^Adjusted results – which control for age, gender, insurance status, employment status, minority status, education, region, and income – show the same pattern and are not shown. *This gap remained statistically significant in the adjusted model (p-value 0.012).

Experiences with Medical Care

Similar to hospital experiences, I found no substantive differences in poor quality experiences reported by sick Democrats and sick Republicans when "dealing with their medical issue" over the past 12 months **(Table 1.14)**. The most commonly cited issue by both subgroups was a

concern about having to "wait a long time for a doctor's appointment", with 36% of sick Democrats reporting this issue compared to 29% of sick Republicans (p=0.28). The only statistically significant difference I detected related to wait times for test results, with more sick Democrats (25%) reporting concerns with this relative to sick Republicans (12%) (p=0.01).

Table 1.14. Percentage of Sick Partisans Reporting a Poor Quality Experience with their Medical Care, by Party *(Unadjusted)*

Poor Quality Experience with Medical Care	Dem	Rep	p-value
You had to wait for an appointment with a doctor longer than you thought reasonable	36%	29%	0.278
You had to bring an X-ray, MRI, or other type of test result with you to a doctor's appointment	25%	21%	0.434
You had to wait for test results longer than you thought reasonable	25%	12%	0.014
You saw a health care professional who did not have all of your relevant medical information	22%	18%	0.423
You did not get all the tests you thought you should	22%	10%	0.023^
You did not get a treatment or test because your insurer wouldn't pay for it	17%	14%	0.574
The doctor of other health professional recommended to you was not accepting new patients or taking your insurance or Medicare	16%	8%	0.056
You were tested or treated for something you thought was unnecessary	15%	16%	0.763
You did not have access to the latest medical technology	15%	12%	0.589
You had to redo a test or procedure because the doctor didn't have the earlier test results	13%	12%	0.857
You could not get an appointment or referral to see a specialist you thought you needed	13%	10%	0.372
You believe you were given the wrong diagnosis, treatment, or test	12%	10%	0.679

Note: Rep, Republican; Dem, Democrat. Questions asked of "sick respondents" (those who reported having an overnight stay in a hospital or having a serious illness, medical condition, injury, or disability that has required a lot of medical care in the past 12 months; n = 516). These are column percentages; the remainder of sick respondents said that they were somewhat or very dissatisfied with their care (or Don't Know/Refused <1%)). ^Though the weighted cross-tabulation results show a statistical difference between the groups, the predictive marginal differences between groups are no longer significant after controlling for age, gender, insurance status, employment status, minority status, education, region, and income.

Experiences with Healthcare Providers

Among the respondents who reported being sick, they were asked whether or not a series of twelve events – that would signal poor quality care – occurred in the past year when "dealing with doctors, nurses or other health care professionals about your own medical problem." Similar to the previous questions related to healthcare experiences, there were no substantive differences between sick Democrats and sick Republicans on these measures related to their experiences with healthcare providers (**Table 1.15**). For example, when asked if a physician "did not treat you with dignity and respect or did not listen to your concerns", only 19% of sick Democrats and sick Republicans answered yes to this question (p=0.98). The most commonly cited concern was that "physicians did not spend enough time with them" (31% sick Democrats versus 23% sick Republicans, p=0.15) or that "the health professional was not accessible by phone or in person" (29% sick Democrats versus 23% sick Republicans, p=0.24).

Table 1.15. Percentage of Sick Respondents Indicating that Item Took Place During Their Interaction with Healthcare Providers, by Party *(Unadjusted)*

Poor Quality Experience with Healthcare Providers	Dem	Rep	p-value
A doctor, nurse or other health professional did not spend enough time with you	31%	23%	0.152
Your condition was not well-managed	29%	19%	0.066
A doctor, nurse or other health professional was not accessible either by phone or in person	29%	23%	0.313
A doctor, nurse or other health professional did not provide all the needed information about your treatment or prescriptions	27%	20%	0.235
You had to see multiple medical professionals, and no doctor understood or kept track of all the different aspects of your medical issues and treatments	23%	20%	0.597
A doctor, nurse or other health professional did not treat you with dignity and respect or did not listen to your concerns	19%	19%	0.983
A doctor, nurse or other health professional did not describe the choices and trade-offs of possible tests or treatments	19%	17%	0.691
You were not treated as well as other patients because of your health insurance situation	17%	11%	0.264

Note: Dem = Democrat; Rep=Republican. These patterns remained in the adjusted logit models that accounted for age, gender, insurance status, employment status, minority status, education, region, and income.

1.4. DISCUSSION

These findings demonstrate that Democrats' and Republicans' views of quality of care are nuanced. Though I observe differences between Democrats' and Republicans' perceptions of the country's quality of care situation and the drivers contributing to national quality of care problems regardless of having a recent interaction with the healthcare system, this study provides no evidence that there are meaningful differences in sick partisans' experiences with care.

Similar to previous surveys showing aggregate level differences by party, I found that Democrats are generally more concerned about the state of quality of care nationally and more likely to report issues as being major contributors to quality of care problems in the country, regardless of having a recent experience with the healthcare system.[10,28] Interestingly, this trend did not persist among the questions related to attitudes towards doctors asked among both healthy and sick respondents. Healthy Democrats were generally more pessimistic in their attitudes towards doctors relative to healthy Republicans; however, sick partisans were comparable in their views on these questions. This may be the result of the fact that sick respondents, irrespective of political party, expressed similar experiences with their recent hospitalization or medical care across nearly all measures examined in this study. This suggests that when questions are framed less as "national" issues, such as perceptions of physicians, one might expect party-level differences seen among a primarily "healthy" general population (with few recent interactions with doctors or hospitals) to narrow among a population that has actually experienced the healthcare system recently. These findings suggest that questions more directly related to a respondent's experience, as opposed to projections of the nation, are less likely to elicit differential responses between Democrats and Republicans.

The findings related to national quality of care issues build upon a political science literature that suggests that "symbolic politics" such as party identification – plays a more important role than self-interest when expressing one's opinions.[14,29] However, in cases where I find a "narrowing of the gap" between sick partisans – which this study suggests may be limited to those questions that feel less hypothetical to the respondent (e.g., those who are sick can envision their doctor when asked about questions regarding physicians), this may provide evidence that there are indeed some cases in which self interest can "trump" symbolic attitudes. Previous studies in political psychology have shown this occurs when policy stakes are clear to respondents personally or when priming has occurred for them to weight the associated benefits and costs of the policy (or issue) that they are assessing.[30]

The main exception to this general pattern was sick partisans' views towards government regulation in healthcare. It was surprising that partisan differences did not exist among sick respondents on this question, especially since I generally observed party politics persist even among sick respondents on measures related to national assessments of quality of care problems. This may be due to the fact that questions using the term "government" can elicit hyper-polarized responses relative to others, especially in light of strong partisan views on the recent health reform law. In these cases, it may be that recent interactions with the healthcare system have the potential to modify these views. Nonetheless, it is important to note that 40% of sick partisans still expressed concern about the implications of excessive government regulation on health care quality. This is consistent with a 2014 study showing national skepticism of government intervention to improve quality of care, such as low levels of trust in government agencies to provide reliable quality ratings of providers.[31]

This study also adds to the evidence that has unveiled a tension between Americans' aggregate perceptions regarding the quality of health care in the system relative to personal experiences.[7,28] Though the majority of sick or healthy Democrats believe that the state of quality of care is problematic, the large majority of them also report being highly satisfied with the care they had recently received. Such high levels of satisfaction with the quality of care that sick respondents feel that they receive personally coupled with the lack of partisan differences in terms of experiences with healthcare quality that I identified in this study may complicate efforts by policymakers to improve the quality of the health care system should such policies be promoted as drastically changing the status quo.

Limitations

There are a number of important limitations to this study. First, this is a cross-sectional survey and I can only suggest potential associations. A more robust panel design that captures partisans' views towards quality of care in a "healthy state" and then follow them through an illness experience to see if their views change would be a useful area for future research. Second, my categorization of "sick" respondents may be too blunt of a proxy for having recent interactions with the health care system. Future research that explores these associations while also incorporating items such as perceived health status (which is known to influence patient and health system satisfaction), illness type/prognosis, provider type, communication with relatives, quality of insurance coverage and more would be very beneficial to see if these patterns persist.[32–34] Third, due to the small sample size in some of the subgroup comparisons, this study may have been underpowered to detect statistical differences between sick partisans. Fourth, this survey took place in March 2012, and subsequent changes to the healthcare system could

potentially change quality of care perceptions and experiences. However, many of these aggregate findings are similar to other polls assessing American attitudes towards quality of care both prior to and after the implementation to the ACA.[8,28,31]

1.5. CONCLUSION

Findings from this national survey to assess attitudes towards quality of care suggest that sick Americans are still partisans when it comes to expressing attitudes about the state of healthcare quality nationally and major problems contributing to quality of care issues in the country. However, in terms of experiences with the health care system on a variety of quality measures, there are no notable differences between sick Democrats and sick Republicans.

Chapter 2

Health Care in the 2012 and 2014 Gubernatorial Elections*

*A version of this chapter has been published in an open-access peer-reviewed journal (Scott KW, Blendon RJ, Sommers BK. "The 2014 Governors' Races and Health Care: A Campaign Website Analysis." INQUIRY. May 2015).

2.1. INTRODUCTION

Political polarization surrounding the Affordable Care Act (ACA) is a well-known phenomenon. Before the final Senate vote that placed the ACA on President Obama's desk, Senate Majority Leader Harry Reid (D-NV) declared: "This legislative fight is one for the record books."[35] Underscoring this fight is the fact that the ACA passed the House (219-212) and Senate (60-39) with not a single Republican vote.[36] Relative to previous major pieces of social legislation in America, including Medicare, the ACA stands alone in that it did not obtain a single vote from the minority party within both Houses.[36] Both the party-line passage of the Affordable Care Act (ACA) in 2010 as well as subsequent divided public opinion regarding the law have contributed to the phenomenon of making health reform a polarizing election issue since its passage in 2010.[37–41]

The politics of the federal law at the state level has risen in prominence since the law's enactment.[42,43] The states have varied in their response to the ACA, and evidence points to the role of politics in influencing these decisions.[41,42] Given that the majority of states have undergone statewide election for governors since the contentious passage of the ACA, it is useful to monitor how the "chief legislator" of the state treats this politicized issue in a context as high stakes as an election. Though governors are only one actor in state policymaking, their preferences matter for shaping the state's policy agenda.[44] Moreover, governors are the most prominent state-level elected official and are held accountable to a state-wide constituency, unlike their counterparts in the state legislature.[45] As the future state executive's preferences can be revealed in an election setting, claims made by prospective governors may indicate how much

political capital they may be willing to invest to facilitate or hinder a policy should they be elected. This seems especially pertinent for a law as politicized as the ACA.

Taken together, the overarching goal of this chapter is to summarize the presence of health policy in gubernatorial elections in both 2012 and 2014, with a special emphasis on the ACA and its key coverage provisions that were implemented in January 2014: Medicaid Expansion and the health insurance exchanges. To do so, I leverage a growing source of political communication data, gubernatorial campaign websites, to capture the role of health policy in the campaigns for governor during this era of health reform implementation.

2.2. MOTIVATION AND THEORETICAL FRAMEWORK

Issue Engagement in Elections

A candidate's effort to engage and inform the public of their stances on campaign issues is important for the functioning of democracy. Throughout the campaign, candidates provide voters with choices on the issues of importance to them.[46] A large body of political science literature has been devoted to studying why candidates opt to focus on certain campaign issues, including issue saliency (how salient is the issue to the candidate's constituents) and issue ownership (theories suggest that candidates strategically engage in particular issues from a given party if the voters believe that their party is better suited to addressing that particular issue).[46–49]

Whether or not a candidate is comfortable with engaging in debate on a particular issue in their campaign, they may be held accountable to take a position on the issue if it is deemed to be important by the public (e.g., one of the most important issues facing the country).[46] Candidates

fear that they may be punished if they ignore the issues that are highly salient to those who cast ballots on Election Day.[50,51] Given the saliency of health care to the public in both 2012 and 2014, it is expected that candidates – at both the federal and state levels – would engage with this topic in their campaigns whether or not they were comfortable doing so.[39,40] Indeed, a recent Brookings study examining campaign websites of congressional candidates found that "Obamacare" was the top issue mentioned among both Republican and Democratic House candidates in the 2014 primary election (79% and 62%, respectively).[52]

With respect to issue ownership, the public has generally considered the Democratic Party as better able to "handle" the issue of health care in the past whereas the Republican Party is better at addressing crime, national defense and so forth.[51,53] This sense of issue ownership has been shown to persist even if the party's actual performance on the issue is not associated with tangible improvements.[54] As such, it would be expected that health care would be a more prominent issue in the campaigns of the party that "owns" the issue. Yet it is unclear that a salient, politicized issue of health reform has changed the likelihood of engagement with the multifactorial term "health care" by the political parties. Throughout the elections since the enactment of the law, pundits have described Democrats as "shying away" from the ACA while Republicans are making repealing "Obamacare" central to their campaigns.[55,56] As such, assessing both the presence of health care and its particular focus by the political parties is important in this era of ACA implementation.

Health Policy as an Election Issue for States

The power of the states in public policymaking has grown over time, especially since the devolution period under the Reagan Administration in the 1980s.[57] States can help to provide resources, staff, expertise, legal authority, fiscal capacity and also political legitimacy to federal regulation.[58] It is not surprising therefore that the role of the states in ACA implementation is paramount.[59–62] The politics of federalism coupled with the politicized tension of the ACA between Republicans and Democrats have heightened the states' political influence over implementation progress.[41,61,63] As two scholars recently summarized: "Reformers must figure out how to make the ACA work in states whose governments are rooting for and working to ensure its failure."[64]

The politics of state ACA implementation has grown even more influential since a Supreme Court decision in June 2012, which took place a few months prior to the 2012 presidential election. At that time, the Supreme Court issued its "surprising" ruling on *NFIB v Sebelius*, upholding the constitutionality of the contentious individual mandate of the ACA but claiming the federal government did not have the power to enforce the ACA's Medicaid expansion policy as a mandate upon the states as intended by the federal law.[65–67] The Court's decision thus permitted each state to determine whether or not they wished to expand Medicaid as called for by the ACA by January 1, 2014.[67] This ruling created much (unexpected) uncertainty around this key coverage provision that would help meet stated goals of the ACA: to reduce the number of uninsured nationwide and improve access to affordable, quality health care.

The subsequent variability in the states' decisions to expand Medicaid or not (or some customized approach) has led to a handful of studies showing that politics has often "trumped" need (e.g., proportion of state residents without insurance) in these decisions.[42,43,68,69] Moreover, it has created a complex situation for "red states" who may find the influx of federal support to expand Medicaid to their citizens fiscally responsible but have an ideological stance against taking part in any aspect of the ACA. This is why it is not surprising that governors from "red states" may be looking to other "red states" states to identify a politically viable alternative to implementing this part of the law.[70]

Another key coverage provision of the ACA that highlights the role of state politics in ACA implementation is the health insurance exchanges. The law requires that any state that did not implement its own exchange in time for the October 2013 open enrollment deadline (in anticipation of the January 2014 launch) would default into a federally-facilitated exchange. An extensive summary by Jones et al. 2014 to study state behavior and politics around the exchanges highlights the "paradox" that conservative state leaders faced when determining if and how they would move forward with the exchanges. On one hand, a state government operating its own exchange would reduce the role of the federal government in the state's health care environment, a political approach favored by states-right activists and conservative leadership. On the other hand, a state that accepted federal funds to create their own exchange could be viewed as helping to implement the ACA, which is a law that the Republican Party has staunchly opposed since its passage.[41] This helps to clarify why many of those states that opted not to create their own exchange – and thus have a federally-facilitated exchange – have been described as having a political environment that is "hostile to the ACA".[71]

The politicized nature of the federal law and its lengthy implementation period makes it somewhat unsurprising that it is continually susceptible to partisanship and electoral debate, and especially at the state level given the states' influence in ACA implementation.[36,72] Moreover, another unexpected Supreme Court decision – announced only days after the November 2014 election – that it would hear arguments for the *King v Burwell* case, which has the legality of subsidies provided to those relying on federal exchange as central to the debate, may have serious and detrimental consequences to this coverage mechanism through the ACA.[71,73] Since this Supreme Court action has created additional certainty around the ACA, it seems to only strengthen the likelihood that states will continue to play an influential role in the law's future.

Unique Role of the Governor & Implications for Health Reform Implementation

Governors play a critical and prominent role in shaping public policy.[74,75] They - as the "chief legislator" - are best suited than any other actor at state level for setting the policy agenda.[76] Their personal preferences will shape which policies will ultimately receive their time and attention on the policy agenda of the state.[44,57] Their public reach is greater than any single state legislator and they have the benefit of the "bully pulpit" to attract attention to their preferences.[57,77] Also, they are generally the best known state official elected as they are elected by a statewide constituency.[78] Moreover, their veto power, state budgetary responsibilities and increased tenure length over time are some characteristics that enhance their power over the state policy agenda.[57,79]

Governors are held accountable for "what happens under their watch".[78] Given the prominence of the ACA since the law's passage in 2010 and implementation activity at the state level, one

could expect that governors are "held accountable" for this salient law's effect upon their state and act according to their preferences and goals. Indeed, there are cases where governors have exercised their executive power and the veto pen to either facilitate or block ACA implementation in their state.[61]

Yet a governor's policy options can be constrained by the state legislature, especially in cases of divided state government.[57,80] In the context of ACA implementation, there is evidence of how governors' interactions with their state legislatures have influenced their decision-making to implement the exchanges, or even cases where the legislature has limited the governor's executive power to do so.[61] Nonetheless, governors play a unique role in the state to signal if they prefer to see the ACA (and its provisions) move forward with their support or to act as a (formidable) barrier to implementation.

Taken together, healthcare has likely been a significant issue for governors to contend with from both a policy and political standpoint as they are in the active process of governing. Previous research on gubernatorial issue attention has shown the motivations for governors to engage with certain issues and set the agenda during state speeches, which offers useful guidance for what candidates will do once elected to office.[44,57,81] However, it is also important to examine what these election-seeking individuals will say when actually campaigning for office.[74] The limited but growing body research on campaign dynamics in gubernatorial elections suggests that candidates act strategically and will stress those issues that they believe will help them win.[74,82] Also, as many governors also run for higher political office, they also must consider how their actions will affect their political reputation.[83] Therefore, they have a vested interest to act

strategically during their campaigns as they will be held accountable for these statements, especially if seeking re-election in the near- or long-term.[48]

Though a number of media sources suggested that health reform, specifically, would be important in recent gubernatorial races, no systematic analysis has been done to identify what gubernatorial candidates actually claimed they would do in their campaigns.[84,85]

A New Method for Studying Gubernatorial Issue Engagement: Campaign Website Analyses

In the past, issue engagement studies in campaigns have been challenging due to data limitations as collecting a robust body of campaign content is both time-intensive and expensive. Given the advent of the Internet and campaign websites, however, political scientists have recently turned to this relatively new data source as a way of studying both issue engagement and issue framing in elections.[46,48,86]

Kamarck and Nye were among the first to comprehensively evaluate the importance of this form of information technology to political campaigns in their analysis of campaign websites in the 1998 election.[87] Candidate campaign websites started to emerge as early as the mid-1990s and, similar to the growth in Internet penetration within the US, their usage has risen over time.[88,89] For instance, in 2002, 55% of Senatorial candidates had campaign websites whereas in 2006, 97% of candidates owned such a website.[90]

Campaign websites primarily serve to provide information about the candidate (biography), their position on issues they feel may be important to their constituency (stated positions, record of

past votes), as well as a tool for soliciting donations and volunteers.[88] Since websites are relatively inexpensive and lack the content limits that are characteristic of other campaign tools, such as television advertisements and direct mailing, they have become an increasingly important campaign tool over time.[91] Moreover, the important Federal Election Commission ruling in 1999 stating that candidates could raise donations through this medium has helped to increase their usage among political candidates.[88]

The communications literature has been particularly apt at documenting the rising trend of campaign website use amongst political candidates and the utility of this new campaign technology in the election cycle.[92,93] A Pew Internet Study found that visits to both Democratic and Republican presidential campaign websites in 2008 were up notably compared to 2004, and voters received email from numerous public officials over the course of the campaign.[89] Though the public is increasingly turning to the Internet to obtain political news, they continue to obtain the majority of political information from television.[89] Nonetheless, evidence has suggested that while the intensity (or the size of the agenda) may differ between candidate's television advertisements and their campaign websites, the differences are minimal between the campaign mediums in terms of actual content and issue positions.[93]

Given the near-universality of campaign website usage among political candidates in elections, they have been viewed as an innovative data source for testing a variety of political theories related to issue engagement and political communication. They have also become an appealing data source for evaluating campaign messaging and issue engagement.[91]

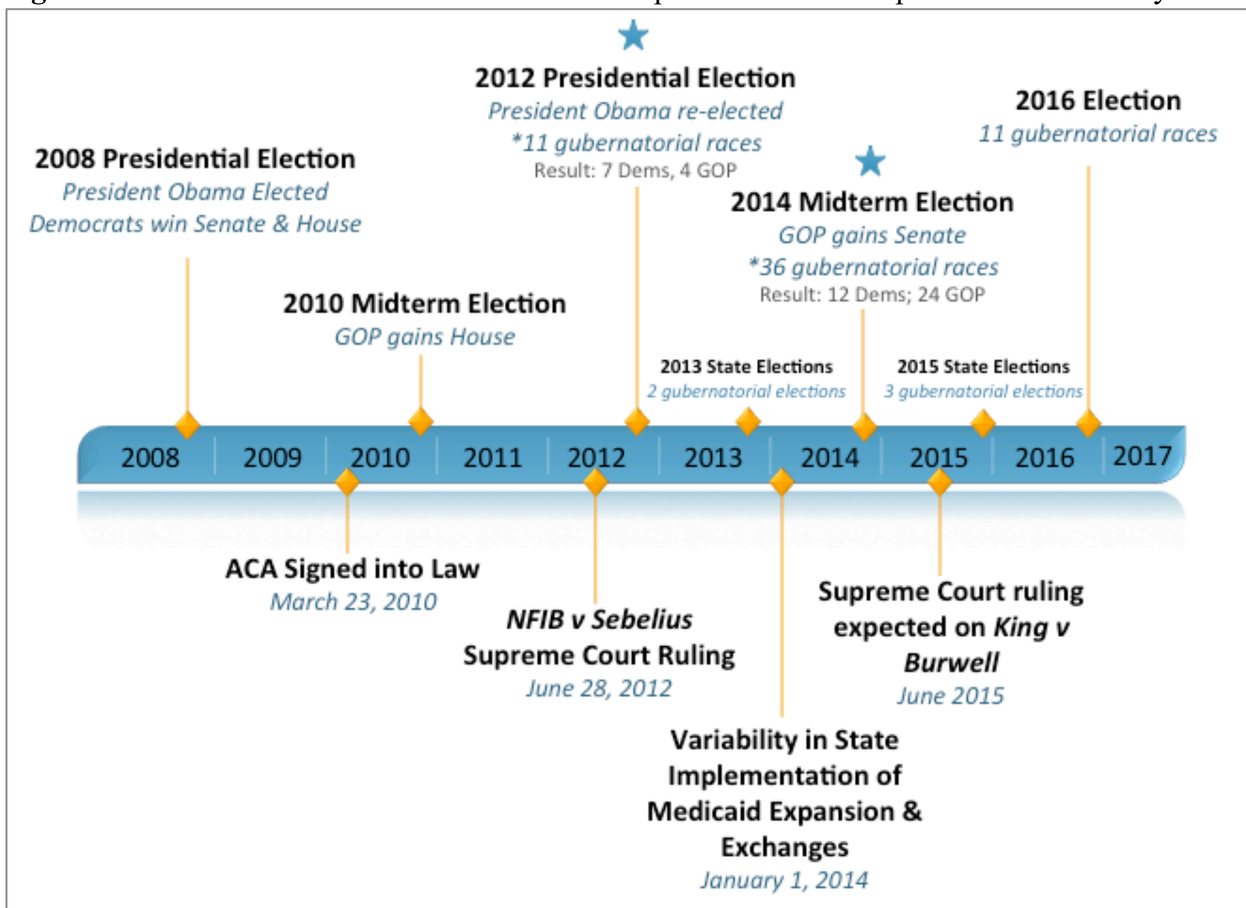
Some political science scholars argue that campaign websites are an ideal data source for evaluating these phenomena for the following reasons: they are 1) unmediated (in that they come directly from the campaign); 2) complete (capture the campaign's overall message and position) and 3) representative of the population of campaigns (e.g., the majority, if not all, candidates now utilize campaign websites in elections).[46] Those skeptical of campaign websites being a useful data source for issue engagement in particular have suggested that because websites permit for an unlimited amount of data to be presented, the presence of particular issues may not signal the actual importance of the issue to the candidate. In other words, a candidate could simply "add" an issue, even if it is not of real importance to them, since the marginal cost of doing so is essentially zero. However, Druckman and colleagues have found that although candidates theoretically have space for much more information, candidates continue to "strategically limit" both the quantity and types of issues that they present on their website.[46]

While scholars have started to document and analyze issue engagement on congressional campaign websites, these analyses typically offer a more holistic overview of the mechanics of campaign websites and how candidates (strategically) utilize this source of political communication. More recently, analyses have started to document issue engagement and strategic campaign communication based on campaign websites.[48,52,91] To date, however, the body of this work has been predominantly focused on congressional races.[46,48,52,86]

2.3. RESEARCH QUESTIONS

Given the saliency of health care and importance of governors in the health reform implementation process, I aim to explore the presence of health policy in recent gubernatorial elections as depicted on the candidate's campaign websites. The 2012 and 2014 gubernatorial elections, which coincide with federal elections, offer a unique opportunity to study gubernatorial candidate issue engagement with a politicized federal health law that has real state-level implications. In **Figure 2.1**, I depict key elections and ACA implementation activity that will be of interest to this study for the aforementioned reasons.

Figure 2.1. Election Timeline and Select ACA Implementation & Supreme Court Activity



Note: A star indicates the two gubernatorial elections that are of focus in this chapter.

For both the 2012 and 2014 elections, I address the following research questions:

1) Did candidates talk about health care on their campaign websites?
2) How much did candidates discuss health care relative to other campaign issues?
3) How did candidates position themselves towards health reform and/or its coverage provisions on their campaign websites?
4) Among winning candidates, what differences emerge, if any, by political party across these measures?

2.4. METHODS

Population

Gubernatorial candidates in the ACA implementation era are the primary focus of this study. As such, I captured data for all Republican and Democratic candidates running for governor in the 2012 and 2014 election cycles, both of which coincide with federal elections **(Table 2.1)**. This population of interest covers 45 unique states, 47 elections, and a total of 94 candidates across the two general gubernatorial elections held in 2012 and 2014.

Table 2.1. Summary of Population and Data Collected

Year	No. of State Elections	No. of Major Party Candidates	No. of Websites Captured	State Abbreviations
2012	11	22	22	DE, IN, MO, MT, NH^, NC, ND, UT, VT^, WA, WV
2014	36	72	71*	AL, AK, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IL, IA, KS, ME, MD, MA, MI, MN, NE, NV, NH^, NM, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT^, WI, WY

Note: No.=Number. A minority of states holds gubernatorial elections in "off years" when there is no national congressional or presidential election (e.g., NJ, VA in 2013 and KY, LA, MS in 2015). These are the only races not included in this analysis, which is focused on those state-level elections that coincide with federal elections. ^Gubernatorial elections are typically held every 4 years, though in two states (NH, VT) they occur every 2 years. *An explanation for the 1 candidate without a website is included in the Methods section.

Data

The primary sources of data for this study were the personal campaign websites of gubernatorial candidates in the 2012 and 2014 gubernatorial elections. Personal campaign websites were collected from the RealClearPolitics (RCP) election center website, which presents race-level

analyses and polling data for each gubernatorial election.[94] RCP also provides direct links to candidates' campaign websites for the major-party nominee for the general election. In the few cases where a third party, typically an Independent candidate, is viewed as competitive, their data are also provided by RCP. In following previous campaign website studies, I did not include official websites that incumbents may have while in office (e.g. Meet the Governor) or sites sponsored by other groups.[46] Through this approach, campaign websites were identified for all but one of the 94 gubernatorial candidates of interest in this study (98.9%).

For the single gubernatorial candidate who did not appear to have a campaign website from this source (Charlie Brown, 2014 Democratic candidate of Tennessee), I searched the state's Secretary of State Election website and official state party website for their campaign website information. Given these attempts were unsuccessful, and additional qualitative assessments of the candidate's seriousness as a gubernatorial candidate was in question by media sources, it was determined that this gubernatorial candidate did not have an official campaign website.[95] Supporting the notion that this particular candidate was not a serious competitor, his opponent – incumbent Governor Bill Haslam (R-Tennessee) won by the largest margin of any gubernatorial candidate in 2014: 47.5 percentage points.

Database Generation

After identifying the candidate's websites, I created a database based primarily on the candidate's website content to answer a range of policy and political dimensions of potential interest. The four broad categories within the data collection tool are: 1) electoral race context information (e.g., state, state expansion status, race competitiveness), 2) candidate characteristics

(e.g., incumbent, gender), 3) candidate website content (e.g., ACA position), and 4) election outcome (e.g., margin of win).

I created this structured data collection instrument through the REDCap database web application tool, and stored all data on this secure platform.[96] A copy of the full data extraction tools used in the 2014 election is available upon request. This gubernatorial elections project was part of a broader initiative to capture congressional candidate website data on health policy in both the 2012 and 2014 elections. The focus of this chapter, however, is limited to gubernatorial candidates only.

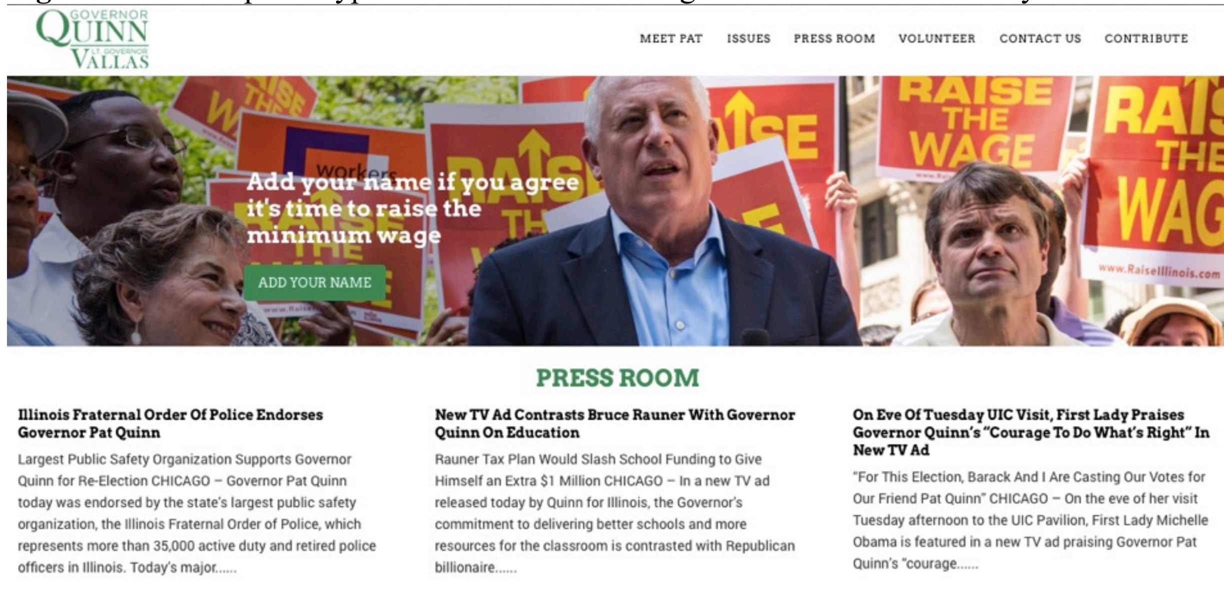
Key Variables & Analysis

To complete this descriptive analysis, I conducted both quantitative and qualitative content analyses of health policy content present in the 2012 and 2014 gubernatorial campaign websites.

Health Policy Presence

To quantify the presence of health policy in the election, I generated two dichotomous variables after reviewing the content provided on candidates' websites: 1) presence of health care as a stand-alone issues page, and 2) presence of health policy on any part of the website. Though the architecture of each website varies, there is generally a home page (i.e., landing page when one selects the website link), donation/volunteer page, a biographical page, and "issues pages" that showcase candidate's positions on relevant policy issues.[46] An example of a typical candidate home page is shown in **Figure 2.2**.

Figure 2.2. Example of typical website structure in gubernatorial election analysis



Note: This is the candidate's home page; the "Meet Pat" tab is the biographical page; the "Issues" tab is where information regarding policy issues is centralized and listed by the candidate.
Source: Governor Patt Quinn (D-IL) campaign website, 2014 (https://www.quinnforillinois.com/).

Following a similar approach used in some congressional campaign website analyses, I captured health-related content that appeared primarily on the home page, biography page and/or issues pages. The primary location of interest to compare the presence of health policy with other policy topics, however, was the candidate's "issues pages". I categorized candidates as having a standard or typical issues tab (where a list of policy/campaign topics was clearly presented) or not. I then recorded the list of topics presented on these issues pages for future reference and data quality assurance. I then indicated whether or not the candidate mentioned any of 29 possible policy topics that I had included in the REDCap database, ranging from education to veterans. The "Other" category denotes candidates that had an issues page dedicated to a different topic not already listed, including those specific to their home state (e.g., "Maine made"). For the analysis, I combined natural groupings of these topics (e.g., transportation and infrastructure) into a single unit to generate an overall summary of candidates' issue pages across

16 policy categories, including health care/health reform. I then calculated the proportion of candidates in each election that had a stand-alone issues page dedicated to health care/health reform (typically titled "Health Care") among all those with standardized issues pages and ranked the presence of this issue relative to the others with stand-alone issues pages.

In cases where no health care tab or issues page was found, I systematically searched the website more broadly under other possible relevant issues pages (e.g., "federal overreach") or news pages, noting both the locations and headings under which any health policy content may have been captured. I then indicated whether or not the candidate mentioned health policy in any form on their website. Regardless of location, I archived each page where health policy content was identified and inputted all unstructured website content focused on healthcare into the REDCap database for future coding and use.

Health Policy Content

Among those candidates who made any explicit mention of any health policy content (e.g., women's health to the ACA) on their website, I conducted a systematic content analysis to generate a more granular variable 1) mentions ACA or coverage provisions, 2) mentions health policy but nothing related to the ACA, or 3) no mention of health policy on website. Among candidates who discussed health policy in both elections, I searched for usage of key terms "access", "cost/affordability" and "quality" and summarize they key themes that emerged based on winning gubernatorial usage of "quality" in the health-related content of their pages.

To identify those pages that specifically discussed health reform, I searched web pages for key terms such as ACA, Affordable Care Act, "Obamacare", and health reform and read each entry in its entirety to confirm that no reference to the health law was found, even on pages dedicated to health care in general. Among those candidates who explicitly mentioned the ACA, I reviewed their statements regarding the law and categorized each candidate's general stance as either in favor of or opposed to the federal law (or unclear/complicated). I also recorded the main reasons offered for any opposition, and whether or not they used the term "Obamacare" in reference to it.

I then systematically searched websites for any mention of the Medicaid expansion policy and indicated those candidates that used the term "Medicaid" on their websites. Based on the content, I then indicated the candidate's position towards the policy, ranging from supporting expansion without hesitation to opposing expansion for their state. Similarly, I quantified the presence of health insurance exchange mentions and whether or not the candidate was in favor of a state-based or federally-facilitated exchange in their state.

External Data Sources

A variety of external sources to the candidate's websites were referenced to capture relevant candidate and election characteristics in this project. For a measure of how partisan the state environment is (i.e., how much it leans towards one of the two political parties), I used the Cook Political Report's Partisan Voter Index score for each state for each election year.[97] I also relied on RealClearPolitics race analyses for incumbency status, race competitiveness and electoral outcomes (which I cross referenced with multiple sources to ensure accuracy, including

Washington Post election results, Politico.com, and Cook Political Report).[94] For state participation with the ACA provisions, I relied upon the Kaiser Family Foundation's analysis of state Medicaid Expansion status and health insurance exchange decisions as of November 1, 2014 to input into the database as the state's status "prior to" the Election. Finally, I rely upon the Kaiser Family Foundation's most recent synopsis of state participation in the ACA (as of March 2015) when describing activity since the election.[98]

Analysis & Presentation of Findings

The unit of analysis in this descriptive study is the individual candidate. For each election year, I summarize the presence of health policy, type of health policy content, and positions towards the ACA coverage provisions for all candidates (winners and losers combined) as well as only successful candidates, stratified by political party. For the 2014 election, I also stratify results by the state's Medicaid Expansion status at the time of the election. Moreover, in terms of health care issue mentions and health system content, I compare and contrast these findings between the two elections within the 2014 section. In some cases, I provide direct excerpts from a candidate's website and indicate the name of candidate, political party, state abbreviation and election year.

Limitations

There are a number of limitations to this study. First, though campaign websites are a useful data source for capturing candidate's issue positions, they are only one mechanism of the political campaign. It is possible that candidates who are categorized as "avoiding" the ACA on their website may have very well discussed it on other campaign platforms, such as television

advertisements, social media or direct mailings. As such, it is not possible to generalize these findings across all campaign platforms. Second, the focus on governors is strategic given their unique role in shaping the policy agenda of their state but also incomplete to provide a complete sense of the political climate surrounding health policy in each state. Governors must balance their preferences towards health policy, electoral prospects, state legislature makeup and budgetary resources to determine their course moving forward. Nonetheless, there is no known analysis to date that has captured the views of governors towards health policy in these important elections for the future of the ACA, thus this study aims to address this gap and generate hypotheses for future research on gubernatorial campaign practices and health reform politics.

Timeline and Ethics Approval

All data were captured on the campaign websites in October 2012/2014, thereby following the conclusion of the primary election season and approximately one month prior to each general election. All analyses were completed in January 2015 using Stata 13.0. This study was reviewed by the Harvard University Committee on the Use of Human Subjects and considered as exempt from human subjects research in both 2012 and 2014.

2.5. RESULTS

I summarize the results for both the 2012 and 2014 gubernatorial campaigns, providing the electoral context for each followed by health policy content results for all candidates, with a special emphasis on the winning candidates in each election.

2.5.1. Results Part I - 2012 Election

Electoral Context - 2012

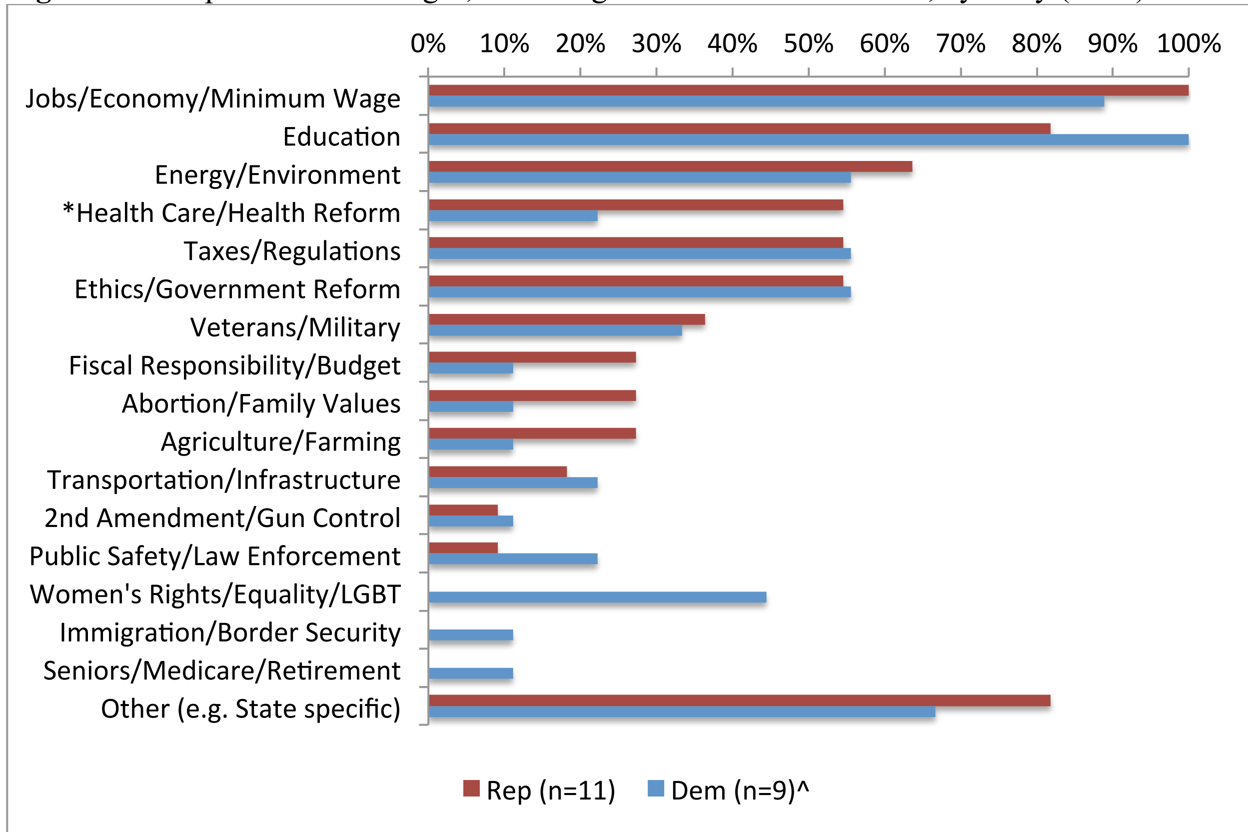
A total of 11 seats were up for election in 2012, which were held by 8 Democrats and 3 Republicans. Democrats lost only one seat overall in the open seat race in North Carolina. Of the seats, all 6 incumbents (2 Republican, 4 Democrat) were re-elected. Overall, the party of the governor barely shifted in these 11 states that encountered state-level elections in 2012.

Issue Presence in the 2012 Gubernatorial Races

Websites were captured for all 22 major-party candidates in the 2012 election (see **Appendix** for web links). A total of 20 (91%) of the candidates had a page dedicated to issues of importance to them in their campaign. The top issues among all 20 candidates with an issues page were jobs/economy (95%), education (90%), energy/environment (60%), taxes/regulations (55%), government reform/ethics (55%), health care/health reform (40%), and veterans/military (35%). Additionally, the majority of candidates (75%) had some sort of state-specific topic on their page (e.g., wolf management, Northern pass) that I denoted as having an "Other" issues page. A partisan divide emerged, however, when examining issue mentions by political party. The

majority of the Republican candidates in 2012 had a page dedicated to health care/health reform (55%) whereas only 22% of the Democratic candidates did so (**Figure 2.3**).

Figure 2.3. Topics on Issues Pages, Percentage of All 2012 Candidates, by Party (n=20)



Note: ^The two Democratic candidates that did not have standard "issues" pages were Peter Shumlin (D-VT) who had a relatively unstructured website, but featured multiple news stories focused exclusively on the state's single payer plan, and Steve bullock (D-MT) who did not have any reference to health care on his website. Two topics included the data extraction tool but not shown (as no candidate presented the issues) were: foreign policy/national defense and constitution/religious freedom.

Health Policy Content in the 2012 Election

Though health care did not rank in the top 5 issues in terms of a stand-alone issues page, a number of candidates shared statements relating to health policy under different headings (e.g., "conservative values" and "regulations"). This explains why a total of 72% (16 of 22) of candidates mentioned health care in some capacity on their site as indicated in **Table 2.2**, which is stratified by political party.

Table 2.2. Health Policy Mentions and ACA Position Presented on 2012 Gubernatorial Candidate Websites, n=22

			Republicans N=11 (%)	**Democrats** N=11 (%)
HEALTH POLICY		Yes, including ACA or ACA provisions	8 (72)	3 (28)
		Yes, but nothing related to ACA or its provisions*	0 (0)	5 (45)
		No mention of health policy	3 (28)	3 (28)
		Of those with issues tabs	*n=11*	*n=9*
		Has dedicated healthcare issues page	6 (55)	2 (22)
		Of those who discussed health policy	*n=8*	*n=8*
		Used term "access"	5 (63)	4 (50)
		Used term "quality"	5 (63)	2 (25)
		Used term "cost/affordability"	6 (75)	4 (50)
ACA POSITION	***Position***	Favor	0 (0)	3 (27)
		Oppose	7 (63)	0 (0)
		Neutral/Complicated	1 (9)^	0 (0)
		No Explicit Mention of ACA	3 (28)	8 (72)
	Framing	*Of those who explicitly mentioned ACA*	*n=8*	*n=3*
		Referred to ACA as "Obamacare"	4 (50)	0 (0)
ACA COVERAGE PROVISIONS	***Medicaid***	No mention of Medicaid	4 (36)	9 (81)
		Mentions Medicaid but not the expansion *per se*	1 (9)[a]	1 (9)
		Opposes Medicaid expansion	3 (28)[b]	0 (0)
		Favors Medicaid expansion (customized approach)	3 (28)[c,d]	0 (0)
		Favors Medicaid expansion (ACA)	0 (0)	1 (9)[c]
	Exchanges	No mention of exchanges	7 (63)	10 (91)
		Opposes establishing state-run exchange	1 (9)[e]	0 (0)
		Not opposed to state-run exchange	3 (28)[c,d]	1 (9)[c]

Note: I provide overall count and column percentages based on denominator noted in table. Columns may not add to 100 due to rounding.
*Examples of other health policy topics include Medicare, women's health, and autism.
^Neutral/complicated was Peter Shumlin's competitor in VT (Randy Brock, R-VT), who focused mainly on criticizing Shumlin's proposed single payer plan, and mentioned only that a contingency plan should be available if ACA repealed (but he did not explicitly state opposition or support).
State abbreviations of candidates that took these positions [a] VT; [b] WV, MO, IN; [c] WA; [d] NH, UT; [e] IN.

The majority of Republican gubernatorial candidates in 2012 discussed the ACA or its coverage provisions explicitly (72%) whereas few Democrats did so (27%). Not surprisingly, support for the ACA was divided by political party; 7 of the 8 Republicans who discussed the law expressed clear opposition to it whereas the 3 Democrats (who mentioned it) expressed their support. Additionally, half of the Republicans who discussed the law referred to it as "Obamacare" whereas not a single Democratic gubernatorial candidate used this term on their campaign website in 2012. For example, David Spence - Republican candidate of Missouri, who ultimately lost to Democratic incumbent Governor Jay Nixon by 12.1 percentage points - used this language on his website to express his opposition to the ACA and intentions to not implmenet its provisions:

> *"Dave stands with the 71% of Missouri voters who rejected Obamacare in 2010. It is the largest tax increase in American history and an unacceptable federal government intrusion into the lives of our citizens. Dave will not implement any mandate -- including the Medicaid expansion -- from Obamacare." –David Spence (D-MO), 2012*

On the other hand, John Gregg - Democratic gubernatorial candidate of North Carolina who lost to Pat McCrory in an open seat race by 11.5 percentage points – expressed his support for the ACA, recognizing it was not without its limitations:

> *"Although the Affordable Care Act (or ACA) is not the perfect law to address our broken health care system, there are several aspects of it that are beneficial, especially for women and families." –John Gregg (R-NC), 2012*

Coverage Provisions in 2012 Election

A. Medicaid Expansion

The 2012 election took place four months following the Supreme Court ruling that permitted states to have the option to implement the Medicaid Expansion provision of the ACA. Only 7 of the of the 22 candidates discussed this provision on their campaign websites (32%). More than half of Republican candidates discussed it (55%), and thus far more relative to their Democratic opponents (9%). Three of the six Republican candidates who mentioned it were opposed to expansion (due to strong opposition to implement any aspect of the ACA) whereas the other three Republican candidates from Washington, Utah and New Hampshire indicated interest in customizing the program to meet the needs of the state (**Table 2.2**).

B. Exchanges

With respect to the health insurance exchanges, even fewer candidates (23%) explicitly mentioned this component of the ACA on their website. At the time, three of the four Republicans who discussed it expressed intentions of moving towards a state-based exchange to provide more oversight of the program. Mike Pence (R-IN), was the single Republican candidate in 2012 to describe his reasons for not wishing to move forward with implementing a state-based exchange through a detailed letter that he wrote to his predecessor, Governor Mitch Daniels:

> *"…it is my recommendation that the State of Indiana should not establish or operate a state–based health insurance exchange under the Affordable Care Act. In a word, Indiana should say 'no' to implementing ObamaCare." – Mike Pence (R-IN, 2012)*

Health Policy Content Among the 2012 Winners

These patterns largely remain among the 11 winning candidates (7 Democrats, 4 Republicans) of the 2012 election. Due to the aforementioned partisan differences combined with the fact that more Democrats were victorious than Republicans, fewer gubernatorial candidates with clear opposition to the ACA were ultimately voted into office in 2012 **(Tables 2.3, 2.4)**.

Table 2.3. Electoral Outcome and ACA Position, 2012 Gubernatorial Election

Electoral Outcome	Republican	Democrat
Won	n=4 50% oppose ACA 50% ignore ACA	n=7 29% support ACA 71% ignore ACA
Lost	n=7 72% oppose ACA 14% neutral towards ACA 14% ignore ACA	n=4 25% support ACA 75% ignore ACA

Table 2.4. Health Policy Mentions and ACA Positions Presented on Winning 2012 Gubernatorial Candidate Websites, n=11

			Republicans N=4 (%)	**Democrats** N=7 (%)
HEALTH POLICY		Yes, including ACA or ACA provisions	2 (50)	2 (29)
		Yes, but nothing related to ACA or its provisions*	0 (0)	3 (43)
		No mention of health policy	2 (50)	2 (29)
		Of those with issues tabs	*n=4*	*n=5*
		Has dedicated healthcare issues page	2 (50)	2 (40)
		Of those who discussed health policy	*n=2*	*n=5*
		Used term "access"	2 (100)	3 (60)
		Used term "quality"	2 (100)	2 (40)
		Used term "cost/affordability"^	2 (100)	3 (60)
ACA POSITION	***Position***	Favor	0 (0)	2 (29)
		Oppose	2 (50)	0 (0)
		Neutral/Complicated	0 (0)	0 (0)
		No Explicit Mention of ACA	2 (50)	5 (71)
	Framing	*Of those who explicitly mentioned ACA*	*n=2*	*n=2*
		Referred to ACA as "Obamacare"	1 (50)	0 (0)
ACA COVERAGE PROVISIONS^	***Medicaid***	No mention of Medicaid	2 (50)	5 (71)
		Mentions Medicaid but not the expansion *per se*	0 (0)	1 (14)[a]
		Opposes Medicaid expansion	1 (25)[b]	0 (0)
		Favors Medicaid expansion (customized approach)	1 (25)[c]	0 (0)
		Favors Medicaid expansion (ACA)	0 (0)	1 (14)[d]
	Exchanges	No mention of exchanges	2 (50)	6 (86)
		Opposes establishing state-run exchange	1 (25)[b]	0 (0)
		Not opposed to state-run exchange	1 (25)[c]	1 (14)[d]

Note: I provide overall count and column percentages based on denominator noted in table. *Examples of other health policy topics include autism programs, a food tax to resolve rising medical costs, and a state-specific senior prescription drug program. ^State abbreviations of candidates that took these positions [a] NH, [b] IN, [c] UT; [d] WA

When considering the race characteristics of these 11 winning candidates, the success of incumbents is noteworthy (though not necessarily surprising due to the incumbency advantage described in political science); all 6 incumbents were re-elected for governor in 2012. When examining the incumbent governors' health policy positions, most of them (5 of 6) did not explicitly mention the ACA on their website. The only exception was Governor Gary Herbert (R-UT) who described his strong dissapointment with the Obama Administration as a result of its denial of Utah's Medicaid waiver proposal along with the philosophy that states are the "incubators of innovation" when it comes to resolving the "crisis" that the healthcare system is in (**Table 2.5**). Also in **Table 2.5**, I provide key excerpts from the health reform statements made by winning governors in open races (where the incumbent did not run again for office due to term limits or choice) next to indicators of race competitiveness and state partisanship, as classified by RealClearPolitics and the Cook Political Report's Partisan Voter Index, respectively. With the exception of incumbency, no clear patterns emerge in terms of winning candidates being more likely to mention their views on the ACA in certain types of races.

Table 2.5. Pre- and Post-Election Characteristics of Winning Candidates (7 Dem, 4 Rep) and ACA Website Excerpts, n=11

Type	Last Name	State	Party	PVI	Margin of Win	RCP Rating	ACA Mention?	Website Excerpt
Inc.	Shumlin	VT	Dem	D+16	20.3	Solid Dem	No^	n/a
Inc.	Markell	DE	Dem	D+8	40.7	Solid Dem	No	n/a
Inc.	Nixon	MO	Dem	R+5	12.1	Likely Dem	No	n/a
Inc.	Tomblin	WV	Dem	R+8	4.8	Likely Dem	No	n/a
Inc.	Dalrymple	ND	Rep	R+10	28.9	Solid GOP	No	n/a
Inc.	Herbert	UT	Rep	R+22	40.6	Solid GOP	Yes - Oppose	…the federal government should look to the states--the true incubators of innovation and ideas--for solutions to the challenges besetting both Medicaid and state budgets.
Open	Hassan	NH	Dem	D+2	12.1	Toss Up	Yes - Favors	Maggie believes we should accept $1 billion in available federal funding to help working families afford health insurance
Open	Inslee	WA	Dem	D+5	2.4	Toss Up	Yes - Favors	…our task is to build on the Affordable Care Act to expand coverage while also improving quality.
Open	McCrory	NC	Rep	R+3	11.5	Likely GOP	No	n/a
Open	Pence	IN	Rep	R+6	3.2	Likely GOP	Yes - Oppose	…I opposed the Affordable Care Act and believe it must be repealed. It erodes the freedom of every American, opening the door for the federal government to legislate, regulate and mandate nearly every aspect of our daily lives under the guise of its taxing power.
Open	Bullock	MT	Dem	R+7	1.7	Toss Up		n/a

Note: Type of Candidate (Incumbent (Inc.) or Open Seat Candidate); Dem=Democrat, Rep=Republican; Partisan Voter Index (PVI) is a measure of state partisanship created by Cook Political Report; Margin of Win = difference between the percent of vote share between major party winners; RCP Rating is pre-election estimate based on RealClearPolitics's pre-election race prediction – ranging from Solid Dem/GOP (least competitive) to Toss Up (most competitive). ^Though Shumlin does not discuss ACA, the majority of website content is devoted to Vermont's single payer proposal. Website content captured from candidate campaign website – see Appendix for web links.

2012 Campaign Statements versus 2015 Reality

The 2012 gubernatorial election took place in November 2012, approximately one year prior to the national rollout of the exchanges and the Medicaid expansion policy. Consequently, I examined what actually happened in those states since the election, comparing the state's participation against the claims of the winning governors (who mentioned the ACA) in 2012. For the two Republican governors that expressed negative views towards the ACA, their participation with the ACA coverage provisions is mixed. In Indiana, for example, Governor Pence was adamantly opposed to the ACA in principle. The state, however, recently received a unique waiver to expand Medicaid in a customized way. For Utah, Governor's Herbert's 2012 campaign statements regarding setting up meetings in Washington to discuss their proposal in greater detail after they were disappointed with the Administration's denial of their initial waiver makes it unsurprising that the state is currently "in discussions" regarding Medicaid expansion; Utah also has the only hybrid exchange (with the federal exchange providing for individuals whereas Utah operates an exchange for small businesses (SHOP)) to date. For the Democrats, one can see – for example – that Washington's governor, in 2012, was fully supportive of moving forward with the ACA and "building upon it" to make further progress. Since the election, Washington has pursued both Medicaid Expansion (indeed as one of the 6 early expansion states) and the exchanges as intended by the law (**Table 2.6**). This suggests that the claims of the governors regarding the ACA or its provisions in the 2014 election may be useful – though by no means perfectly predictive of future action – to inform future steps that they may take (or not) to implement these particular provisions of the law.

Table 2.6. State Participation in Key Coverage Provisions as of March 2015 Among Governors who discussed ACA in 2012 Campaigns

State	Governor	ACA Framing	Party	Medicaid Expansion Status^	Exchange Status^
UT	Herbert	Negative	Rep	Not expanded but in discussions	Federal (individual); State (SHOP)
IN	Pence	Negative	Rep	Adopted Expansion with waiver	Federal
WA	Inslee	Positive	Dem	Adopted Expansion**	State
NH	Hassan*	Positive	Dem	Adopted Expansion with waiver	Partnership

Note: State=State Abbreviation; Rep=Republican; Dem=Democrat; ^Status according to Kaiser Family Foundation as of March 2015. *Governor Maggie Hassan (D-NH) faced re-election in 2014 as both NH and VT hold 2-year terms. **Washington was one of the 6 early expansion states along with California, Connecticut, the District of Columbia, Minnesota, and New Jersey.

2.5.2. Results Part II - 2014 Election

Electoral Context - 2014

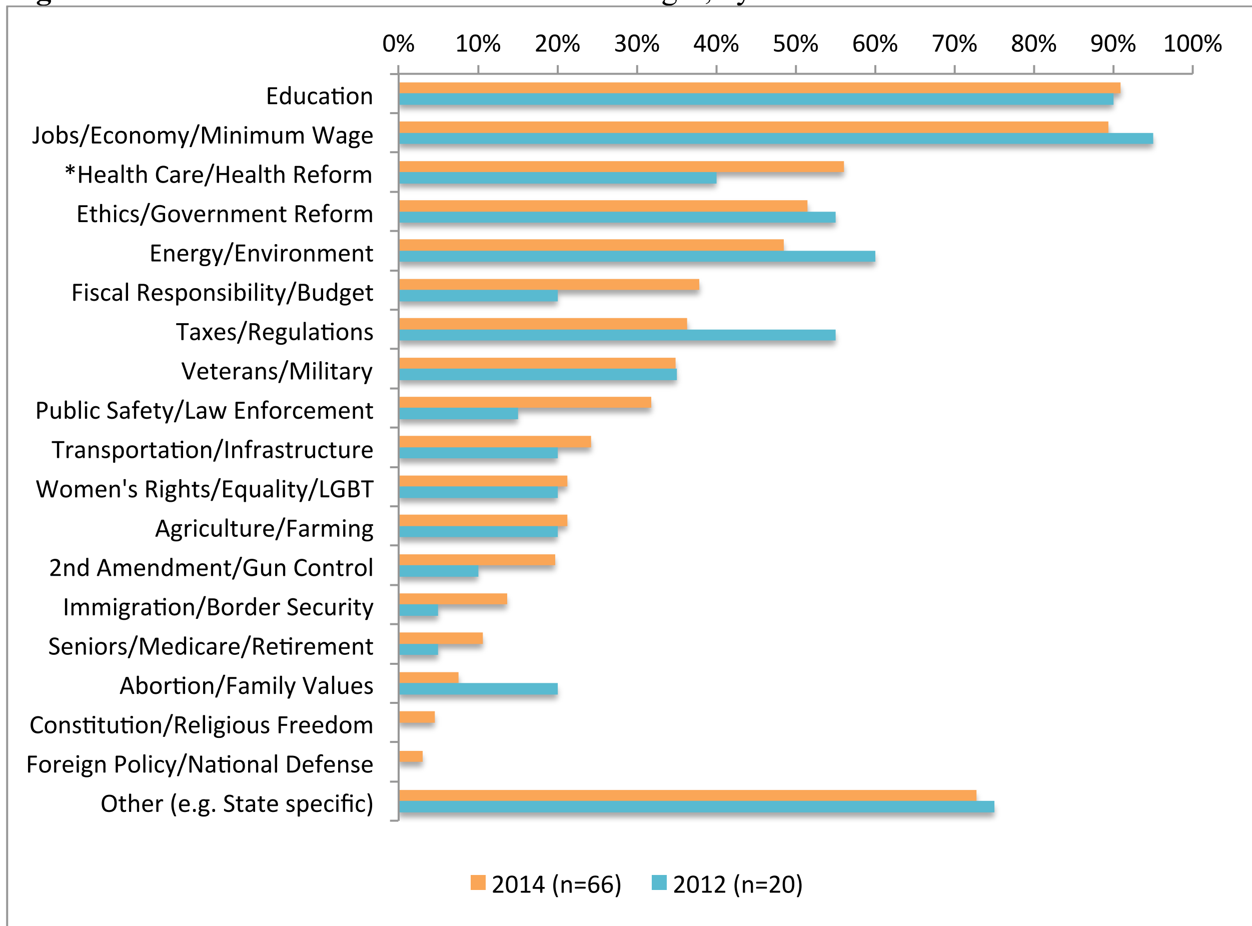
A total of 36 governorships were contested in 2014 relative to the 11 in 2012. Prior to the election, Republicans held the majority of these 36 seats (22 Republicans versus 14 Democrats). A total of 6 states witnessed a change in their governor's political party following the election, with 4 Republicans "picking up" seats from Democrats in Arkansas, Illinois, Massachusetts and Maryland, 1 Democrat gaining a previously held Republican seat in Pennsylvania, and 1 Independent candidate defeating the Republican incumbent in Alaska. Unlike in 2012, Republican gubernatorial candidates fared better than the Democrats in the 2014 election. Similar to 2012, however, nearly all of the 28 incumbents in 2014 (9 Democrats, 19 Republicans) were successful in their re-election campaigns. The only three incumbents to lose in 2014 were Sean Parnell (R-Alaska), Patt Quinn (D-Illinois), and Mark Schauer (D-Michigan))

Issue Presence in the 2014 Gubernatorial Races

Campaign websites were captured for nearly all major-party candidates in the 2014 election (71 of 72 candidates) (see **Appendix** for web links). The exception was Charlie Brown (D-TN) who did not have a website and was excluded from all analyses in this chapter (see Methods section for explanation). For the ease of comparison, I summarize the results by the 36 Republican candidates and the 35 non-Republican candidates (34 Democrats + 1 Independent) that had websites.

Unlike the 2012 election, health care/health reform was presented on the "issues pages" by the majority of gubernatorial candidates (56%) in 2014, ranking behind the top two issues of education (91%) and jobs/economy (89%) **(Figure 2.4)**. In general, the top 10 issues were similar across the two election years, but dedicated health care issues pages were more commonly listed on the campaign websites of gubernatorial candidates in the 2014 election relative to the 2012 election.

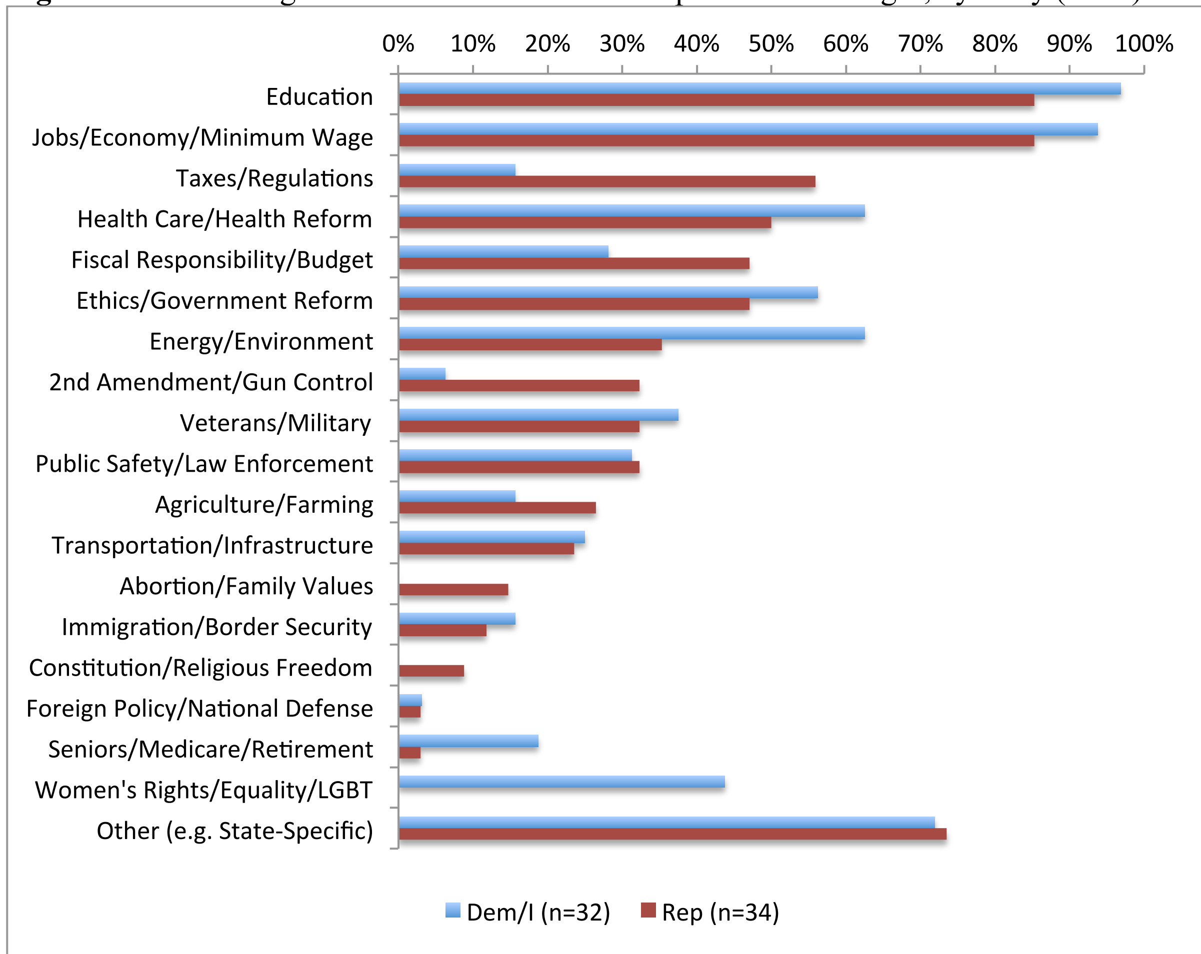
Figure 2.4. Issue Presence on Candidate Issues Pages, by Election Year



Note: The bars represent the percentage of candidates (n) with dedicated issues-pages to each topic, by election year. Examples of "Other" pages in the 2014 election include: "Maine made", "Reclaiming the title as America's Disneyland", and "Illinois comeback".

Though more Republican candidates had dedicated health care issues pages relative to Democrats in 2012, this was not the case in 2014. Slightly more Democrats had dedicated health care/health reform pages (62.5%) relative to Republicans (50%) (**Figure 2.5**). Additionally, 44% of Democrats had pages focused on Women's Rights, often focusing on health care in the same page as equal pay, whereas no Republican candidates had dedicated pages to this topic.

Figure 2.5. Percentage of 2014 Candidates with Topic on Issues Pages, by Party (n=66)



Health Policy Content in the 2014 Election

When looking across the range of issues pages to identify health policy content, the large majority of candidates (nearly 80 percent) discussed health care in some capacity on their website, ranging from women's health to medical research (**Table 2.7**). Though the predominant focus of the candidates was on the ACA or its coverage provisions, other topics such as mental health or substance abuse control were presented on the websites by multiple candidates.

Table 2.7. Health Policy Mentions and ACA Position Presented on 2014 Gubernatorial Candidate Websites, n=71

			Republicans N=36 (%)	**Democrats/Ind.^** N=35 (%)
HEALTH POLICY		Yes, including ACA or ACA provisions	22 (61)	22 (63)
		Yes, but nothing related to ACA or its provisions*	5 (14)	7 (20)
		No mention of health policy	9 (25)	6 (17)
		Of those with issues tabs	*n=34*	*n=32*
		Has dedicated healthcare issues page	17 (50)	20 (63)
		Of those who discussed health policy	*n=27*	*n=29*
		Used term "access"	6 (22)	17 (59)
		Used term "quality"	8 (29)	13 (45)
		Used term "cost/affordability"^	17 (63)	18 (62)
ACA POSITION	***Position***	Favor	0 (0)	5 (14)
		Oppose	20 (56)	2 (6)
		Neutral/Complicated	0 (0)	6 (17)
		No Explicit Mention of ACA	16 (44)	22 (63)
	Framing	*Of those who explicitly mentioned ACA*	*n=20*	*n=13*
		Referred to ACA as "Obamacare"	18 (90)	4 (31)
ACA COVERAGE PROVISIONS	***Medicaid***	No mention of Medicaid	24 (67)	17 (49)
		Mentions Medicaid but not the expansion *per se*	2 (6)	1 (3)
		Opposes Medicaid expansion	6 (17)	0 (0)
		Favors Medicaid expansion (customized approach)	4 (11)	3 (9)
		Favors Medicaid expansion (ACA)	0 (0)	14 (40)
	Exchanges	No mention of exchanges	25 (69)	24 (69)
		Supportive of exchange status quo	9 (25)	8 (23)
		Indicates plans to change exchange setup	2 (6)	3 (9)

Note: ^For the ease of comparison, I summarize the results by the 36 Republican candidates and the 35 non-Republican candidates (34 Democrats + 1 Independent) that had websites (see Methods section for explanation of the single Democratic candidate without a website). *Examples of non-ACA topics include mental health, opiate control, and Medicare. ^The Democrats who lost were more likely to use the term "affordability" relative to Republicans – but winning Democratic candidates and winning Republican candidates used these terms more interchangeably. The concept across both parties relates to paying for health care so I have grouped them together for the ease of presentation.

Similar to the 2012 election, language related to health care "costs" and "affordability" of care dominated the content that candidates devoted to healthcare on their websites. In 2014, over 60 percent of candidates using these specific terms on their website when providing statements related to health policy. The terms "access" and "quality" were used less frequently than costs, though more Democratic candidates used these terms relative to Republicans. This appeared to be especially true for the term "access" in 2014; 59% of Democrats versus 22% of Republicans used this term on their campaign websites. These differences, however, were not apparent within the gubernatorial candidates who discussed health policy in the 2012 election.

Though slightly more Democrats had dedicated issues pages on health care relative to Republicans, they were less likely than Republicans to mention their views on the federal law explicitly. For example, Democratic gubernatorial candidate Martha Coakley (D-MA), who ultimately lost to Republican competitor Charlie Baker by a slim margin, had a "Healthcare" issues tab but did not make any explicit reference to the ACA within it. Rather, she discussed her overarching goals of the state's health care system with a special focus on mental health care:

> *"Massachusetts has long been a national leader in providing high-quality, affordable health coverage to our citizens; the Commonwealth is home to some of the best hospitals in the world, and our companies are on the cutting edge of medical innovation. Our goal today must be to balance that world-class level of access and quality with affordability, and to recognize the importance of caring for those with behavioral health issues with the same commitment with which we care for those facing challenges to their physical health." –Martha Coakley (D-MA), 2014*

For those candidates who discussed the federal law, there is a similar partisan divide in terms of support levels for the ACA as was seen in 2012. When Democrats discussed the ACA, their

views were generally favorable (though not without some disclaimer that the law is far from perfect) whereas Republicans were strongly opposed.

In terms of the ACA coverage provisions, relatively few candidates (31%) discussed the health care exchanges on their website. However, nearly half (49%) of the Democratic gubernatorial candidates mentioned the Medicaid expansion provision in their campaigns (though they did not explicitly link it to the ACA) whereas fewer Republicans brought up Medicaid expansion. For example, Democratic gubernatorial candidate of South Carolina, Vincent Sheehan, criticized his opponent – incumbent Republican governor Nikki Haley (R-SC) – for rejecting the Medicaid expansion policy, but never directly mentioned anything about the broader federal law:

> *"Refusing to expand Medicaid hurts South Carolinians: Sends $11.7 billion in new revenue to other states instead of putting it to work in-state. Kills 44,000 new jobs. Subjects local businesses to $30-45 million in penalties annually. Increases premiums for SC citizens purchasing private health insurance. Puts our rural hospitals in dire straits and hurts SC Community Health Centers. Leaves more than 200,000 SC citizens with no coverage or assistance, including 51,000 seniors age 50-64 and 13,000 veterans and their spouses. One of the first steps Vincent will take when he is governor is to restore common sense, and keep our Federal Medicaid tax dollars in South Carolina for working families and medical providers. Leadership matters. Honesty matters. And a common-sense approach is important. It's time for a change in South Carolina."*
> *–Vincent Sheehan (D-SC), 2014*

The use of "Obamacare" among 2014 Candidates

Among all candidates, the large majority of those who referenced the ACA as "Obamacare" were Republican candidates who used the term in a negative tone. The following excerpts from the campaign websites of the Republican governors of Georgia and Arkansas are emblematic of how the term was used by these candidates:

> *"Under Obamacare, Georgians have suffered among the nation's highest health insurance premium increases. The failed federal takeover of health care has already led to higher taxes and millions of policy cancellations. Gov. Deal refused to waste state resources and taxpayer money to create an insurance exchange and remains opposed to expanding Medicaid. " –Nathan Deal (R-GA), 2014*

> *"I have consistently opposed Obamacare from day one and I will continue to do so. It is a terrible job killing policy that is fatally flawed. Ultimately, the only way to end this job killer is for Congress to repeal the law. The Arkansas legislature was handed a terrible program and had to choose how to deal with Obamacare. There was no good option for the state and there never will be unless Obamacare is repealed and replaced."*
> *–Asa Hutchinson (R-AR), 2014*

Unlike in 2012, when no Democrats used the terminology "Obamacare" when discussing the ACA on their website, there were four Democratic candidates who did so in their 2014 gubernatorial campaign. Each of these candidates ultimately lost in their state, three of which had strong Republican leanings according to the state's partisan voter index (PVI) (**Table 2.8**).

Table 2.8. Democrats who used term "Obamacare" on their website, by State and PVI

Name	Party	State	PVI	Campaign Website Excerpt
Mike Ross	D	AR	R+14	"I voted against the federal health care law, or the Patient Protection & Affordable Care Act (also known as 'Obamacare'), four times and I voted to repeal Obamacare 23 times. But, at the time, I said there were good parts and there were bad parts to Obamacare. I think Arkansas's Medicaid expansion, which passed with overwhelming Republican support, is one of the good parts. Whether you support or oppose Obamacare, expanding Medicaid in Arkansas was the right thing to do, and I commend Gov. Beebe and both parties in the state legislature for finding an Arkansas-specific and market-based solution to this important debate."
Joe Dorman	D	OK	R+19	"We need a Governor who is willing to drop the partisan games and find pragmatic approaches to ensure Oklahomans can access the healthcare they need. Obamacare, Medicaid, Medicare, you name it - it's all a mess. No one has the perfect solution, but here's the straight truth: continuously focusing on the politics of health care is helping no one."
Parker Griffith	D	AL	R+14	"Under the Griffith plan, which would require a waiver from the federal government because it is a market-based solution that uses private insurance instead of the standard Medicaid structure under the Affordable Care Act (ObamaCare), the federal government would pay 100 percent of additional health care costs for the first three years, with the state responsible only for administrative costs.
Anthony Brown	D	MD	D+10	"Implementing Obamacare: As the leader of Maryland's efforts to improve health care and Co-Chair of the Health Care Reform Coordinating Council, Lt. Governor Brown has positioned Maryland as the national leader in the implementation of the Affordable Care Act. The Lt. Governor has ensured that all Marylanders are able to access the benefits provided under the Affordable Care Act."

Note: Columns from left to right include: candidate name; Political Party (D=Democrat, R=Republican), State Abbreviation, PVI=Partisan Voter Index (a measure of state partisanship created by Cook Political Report); Website excerpt from 2014 campaign website, with "Obamacare" reference underlined.

Health Policy Content by Incumbent Status, 2014

Given the dominance of incumbents in 2014 (as was seen in 2012), I examined whether or not there were differences in health policy mentions among incumbents, stratified by political party. Unlike in the 2012 election, I found that the majority of the 9 Democratic incumbents in 2014

discussed either the ACA or its coverage provisions in their campaigns (67%) and essentially the same percentage of the 19 Republican incumbents did the same (68%). However, when looking at explicit references to the ACA, one can see a similar trend to 2012 where fewer Democratic incumbents discussed the law *per se* (33%) relative to Republican incumbents (58%). In other words, when the law was specifically mentioned by incumbents, it came up more often by its opponents than its proponents.

Health Policy Content Among the Winners, 2014

Among the winning candidates of the 2014 election (24 Republicans, 12 Democrats), the large majority of them discussed health care on their website (80%) **(Table 2.9)**. Similar to the pattern noted above, the predominant health policy topic of interest to the winning candidates was the ACA (or its coverage provisions). A total of 25 of the 36 (69%) winning candidates explicitly discussed their views on these policies on their websites in 2014.

Table 2.9. Health Policy Mentions and ACA Position Presented on Winning 2014 Gubernatorial Candidate Websites, n=36

			Republicans N=24	**Democrats/Ind.**[*] N=12
HEALTH POLICY		Yes, including ACA or ACA provisions	17 (71)	8 (67)
		Yes, but nothing related to ACA or its provisions*	3 (13)	1 (8)
		No mention of health policy	4 (16)	3 (25)
		Of those with issues tabs	*n=23*	*n=11*
		Has dedicated healthcare issues page	14 (61)	6 (55)
		Of those who discussed health policy	*n=20*	*n=9*
		Used term "access"	5 (25)	4 (44)
		Used term "quality"	7 (35)	3 (33)
		Used term "cost/affordability"	14 (70)	4 (44)
ACA POSITION	***Position***	Favor	0 (0)	3 (25)
		Oppose	15 (62)	0 (0)
		Neutral/Complicated	0 (0)	2 (17)
		No Explicit Mention of ACA	9 (38)	7 (58)
	Framing	*Of those who explicitly mentioned ACA*	*n=15*	*n=5*
		Referred to ACA as "Obamacare"	13 (87)	0 (0)
EXAMPLES OF NON-ACA TOPICS[^]		physician shortage *(e.g. increase residency slots)*	3 (SD, IA, OK)	3 (HI, AK, PA)
		medical research & technology *(e.g., cancer)*	3 (FL, GA, OH)	1 (RI)
		mental health/substance abuse *(e.g., opiate control)*	3 (OH, WY, TN)	4 (VT, CT, AK, NH)

Note: *Of the 36 newly-elected governors, 24 are Republicans, 11 are Democrats and 1 is Independent (AK).
[^]Additional non-ACA specific health policy topics were presented on websites, such as primary care medical homes, but I have only listed those that were mentioned multiple times by members of both parties (and their corresponding state abbreviations).

Among the 12 winning Democrats, over half avoided talking about the ACA *per se.* In contrast, the majority of the 24 winning Republicans (62%) mentioned their unfavorable views towards the federal law (though only a few expressly called for its "repeal"). Among the winning candidates who mentioned the ACA, Republicans overwhelmingly referred to it as "Obamacare" (87%) whereas not a single winning Democrat used this term. The top reasons that Republicans offered for their ACA opposition were that it the law was "a failure" (53%), represented federal overreach into states (47%), raised premiums (47%) or caused plan cancellations (40%).

Of the 7 winning candidates (4 Republicans, 3 Democrats) that did not clearly bring up the topic of health care on their websites, all of them were from states that had both expanded Medicaid and opted for a state-based (or partnership) exchange (IL, NM, MD, NV, CO, RI, NY). This may suggest that winning candidates in states that had engaged with parts of ACA implementation – regardless of political party – did not opt to showcase their state's prior actions as policy accomplishments on their website.

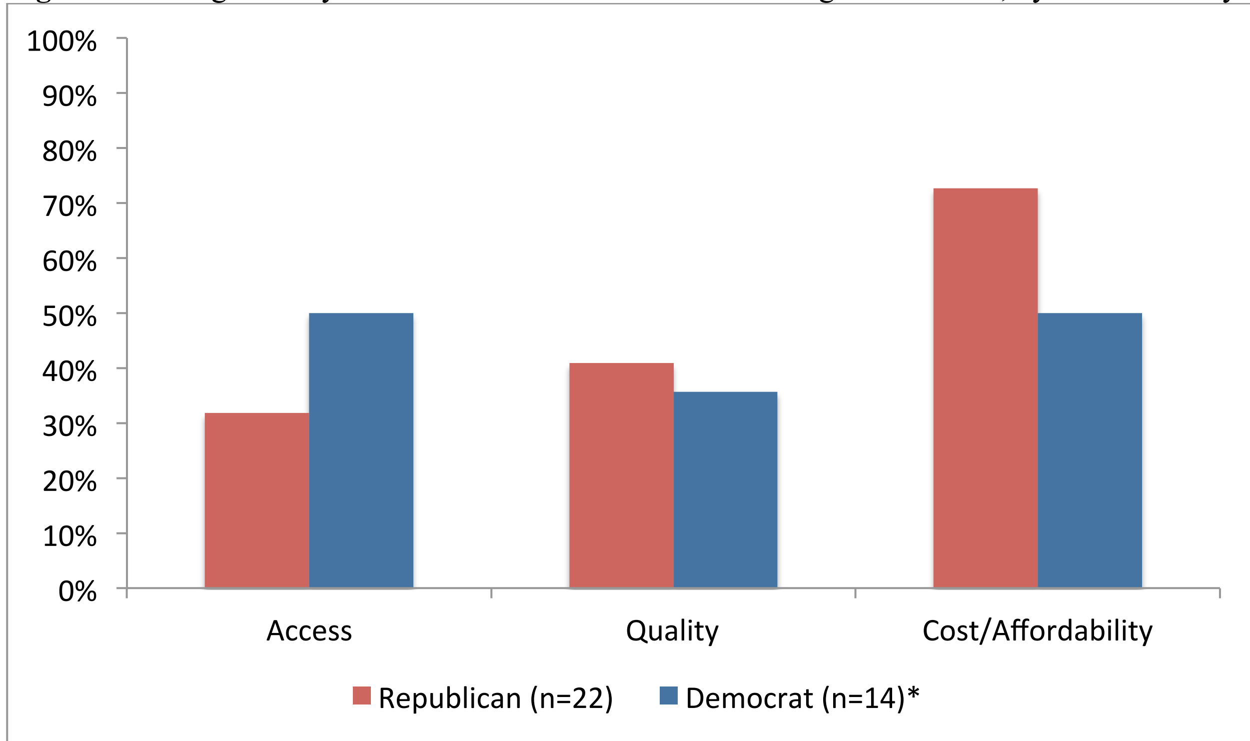
Themes of Health Policy Content

Among the 36 winning candidates, I explored the content related to health care found on the 29 governors (81%) who discussed healthcare on their websites (20 Republicans, 9 Democrats/Independent). Focusing on the three terms of "costs/affordability", "access" and "quality", the majority of winning candidates (66%) used the terms "costs/affordability", whereas both "quality" and then "access" appeared on approximately one-third of them (33% and 31%, respectively). By political party, a greater proportion of Republicans used terms related to "costs" relative to Democrats whereas more Democrats used the term "access" more

than Republicans. Essentially the same percentage of candidates from both parties used the term "quality" (33%) (**Table 2.9**).

When combining the two election years, and focusing on those winning candidates only that had health policy content on their website, it is not surprising to see this pattern continue as the majority of the 47 elections took place in 2014 (**Figure 2.6**).

Figure 2.6. Usage of Key Terms in Health Care Content Among All Winners, by Political Party



Note: Across the 2 election years, Republicans won 28 of the 49 possible races, while Democrats (plus one Independent) won the remaining 21 seats. Of those candidates, 22 Republicans discussed health policy in some capacity on their websites whereas 14 Democrats did so. I summarize here the collective usage of the terms "access", "quality" and "cost" or "affordability" within the health-related content captured on the winning candidates' websites across both election years.

Given the similarities in usage of the term "quality" between both political parties, I examined the content of these winning candidates' statements regarding quality of care across both election

years. When doing so, I found that a greater proportion of candidates brought up issues directly related to quality, including electronic medical records and hospital readmissions, even in cases where they did not use the specific term “quality”. For example, if I were to broaden this definition of candidates who presented quality of care on their websites, one would see the proportion of candidates who discussed quality of care rise to nearly 50% in both parties in 2014.

When examining the usage of these three particular terms (costs/affordability, quality, and access), a number of candidates used at least two of these terms within the same phrase to describe their goals for the health system. For instance, Governor Rick Scott’s explanation of his Medicaid reforms in Florida demonstrates how a candidate may use each of these terms in a single sentence:

> *“Gov. Scott led the implementation of historic Medicaid reform to improved access and quality of care and controlled costs." –Rick Scott (R-FL), 2014*

Additionally, Maggie Hassan (D-NH) who was elected in 2012 and re-elected in 2014 described her 2012 health care priorities as follows:

> *"We need to ensure that quality, affordable health care is a reality for everybody here in New Hampshire, which means controlling costs and protecting successful programs like Medicare." –Maggie Hassan (D-NH), 2012*

Looking across both parties in both elections, I found that a number of candidates used language to demonstrate their goal to focus on paying for quality or value as opposed to quantity of care. For instance, Governor Bill Haslam of Tennessee described these goals for his Medicaid reform proposal in the 2014 election, as did Governor Herbert of Utah in his 2012 election:

> *"The Tennessee Plan would allow for patient co-pays, healthy living incentives, and other personal responsibility measures. It would also include reforming the way providers are reimbursed, so that positive outcomes are rewarded and the state is paying for value and not just volume." –Bill Haslam (R-TN), 2014*

> *"... Utah's proposal includes five innovative components: Change financial incentives for doctors, rewarding quality instead of quantity." –Gary Herbert (R-UT), 2012*

Additionally, Peter Shumlin (D-VT) described a similar sentiment regarding the need to build payment incentives around quality versus quantity in relation to his single payer plan:

> *"The system will be publicly financed so everyone pays based on their ability and by moving to a system where quality of care is rewarded over quantity of services, Vermont will save money." –Peter Shumlin (D-VT), 2014*

Nonetheless, while there may be bipartisan interest for aligning incentives to reward quality over quantity, some website excerpts suggest that the quest for quality may still be framed in light of ACA polarization. For instance, Governor Nathan Deal of Georgia who is strongly opposed to the ACA described his commitment to seeking "innovative" solutions to improve quality of care:

> *"Gov. Deal is determined that Georgia will lead the country finding innovative solutions to improve health quality, even in the midst of rising costs under Obamacare. That's why he's initiated work on our state's second National Cancer Institute-designed Cancer Center, added autism coverage to the State Health Benefit Plan, and increased the number of residency slots to keep more young doctors in state." –Nathan Deal (R-GA), 2014*

Other Health Policy Topics

Though the ACA and its provisions were the primary focus on any of these candidate's health issues pages, a few of the newly-elected governors from both parties brought up healthcare issues that were not directly focused on the ACA in the 2014 election. This includes concerns

with physician shortages in their state (e.g., need to increase residency slots, attract providers to rural areas), goals to improve mental health care services, and a need to control substance abuse (**Table 9**). For example, though he did not mention anything related to health reform on his website, Governor John Kasich (R-OH) discussed his views on drug abuse and autism under a web page titled "Fighting for the Underdog":

> *" Helping Families Impacted By Autism: Thousands of Ohio families find themselves coping with the financial and emotional struggles that come with raising a child with Autism Spectrum Disorder (ASD), the fastest-growing developmental disability in the United States. Through an executive action effective July 2013, Governor Kasich provided insurance coverage of ASD to all state employees" –John Kasich (R-OH), 2014*

Additionally, the Republican Governor of Iowa devoted a large portion of his healthcare page to mental health:

> *"Governor Branstad is committed to a sustainable mental health system that benefits all Iowans. Since mental health redesign began more than two years ago, Iowa taxpayers have invested more than $115 million into mental health funding statewide." –Terry Branstad (R-IA), 2014*

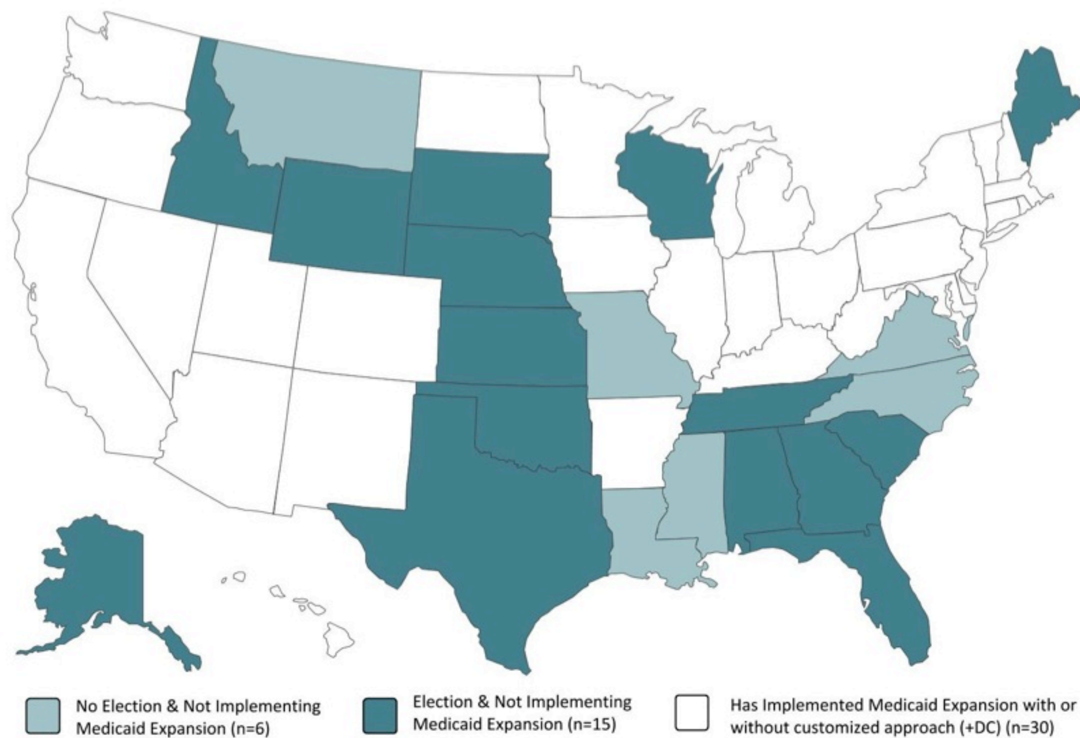
Coverage Provisions in 2014 Election

A. Medicaid Expansion

The 2014 election was the first since the key provisions of the ACA – Medicaid expansion and the health insurance exchanges – were implemented by a number of the states. Given, the pre-election variability in state participation with both of these provisions, I observed how candidates in participating versus non-participating states treated each issue in their campaign, if at all. Of

particular interest to the media prior to the election, were the races in the 15 states holding gubernatorial elections in 2014 that had not yet opted to expand Medicaid in any way (**Figure 2.7**). The general notion was that if Republicans (who held these seats) lost these races, then options for Medicaid expansion might have been more politically viable with a Democratic governor in office.[85]

Figure 2.7. States that Had Not Expanded Medicaid as of November 2014, by Election Status



Source: Created by author using election status and Medicaid expansion status gathered from Kaiser Family Foundation & Commonwealth Foundation websites as of November 1, 2014.[99]

When summarizing the electoral outcomes of the governors stratified by the state's Medicaid expansion status at the time of the election, it is apparent that the party of the governor barely shifted in these non-expansion states following the election **(Table 2.10)**. With respect to the states that had already expanded Medicaid, Republicans witnessed a net gain of 3 seats.

Table 2.10. Breakdown of Medicaid Expansion States and Electoral Performance (counts)

	EXPANSION STATES WITH ELECTIONS *(n=21)*				NON-EXPANSION STATES WITH ELECTIONS *(n=15)*			
Party of Governor	**Pre-Election**	**Post-Election**	**Change in Party**	**States with Change**	**Pre-Election**	**Post-Election**	**Change in Party**	**States with Change**
Rep	7	10	4 Rep Pickups	AR, IL, MA, MD	15	14	n/a	n/a
Dem	14	11	1 Dem Pickup	PA	0	1	1 Ind. Pickup	Alaska

Note: Rep=Republican; Dem=Democrat; n/a=not applicable.

Within **Table 2.11**, I summarize the percentage of winning candidates who mentioned both the Medicaid expansion policy and health insurance exchanges on their websites along with the general positions they took, if any. I describe these findings in terms of Medicaid expansion status below.

Races for the next governor took place in three-quarters of the 28 states that had already expanded Medicaid in some form as of Election Day. Less than one-third (29%) of the newly-elected governors in these states discussed Medicaid on their website **(Table 2.11)**. This may suggest that the large majority of these states have governors that do not intend to fundamentally change the state's participation in the Medicaid expansion. However, this was not true for all. Specifically, Arizona and Arkansas elected new Republican governors who expressed willingness to explore options that would move their state in the other direction as shown below:

> *"As someone who has always opposed expansion of government and the train-wreck known as the Affordable Care Act (Obamacare), I am frustrated with the limited options that are left to each state. I view the Private Option as a pilot project; a pilot project that can be ended if needed." –Asa Hutchinson (R-AR), 2014*

> *"I will lead the effort to negotiate a Medicaid waiver for Arizona and to protect our state from Obamacare, one of the worst laws ever signed by any American president."*
> *–Doug Ducey (R-AZ), 2014*

Alternatively, in Pennsylvania – a state with a customized plan in place – newly-elected Democratic governor Tom Wolf criticized his Republican opponent and predecessor for not taking full advantage of a traditional Medicaid expansion under the ACA and thus may consider revising the state's current customized waiver option.

> *"As indecision and inaction have dominated discussions, the Corbett administration has ignored the fact that implementation of the Affordable Care Act and the expansion of the state's Medicaid program provides an unprecedented opportunity to give more than 500,000 currently uninsured, middle and low-income Pennsylvanians access to affordable health care. Expanding health care to hundreds of thousands of Pennsylvanians and their families is not just the right thing to do; it's good for the economy and will create jobs." –Tom Wolf (D-PA), 2014*

Table 2.11. Presence of Medicaid Expansion and Exchanges among Winning Governors in 2014, by Political Party (n=36)

		All Winning Candidates (n=36, 24 R, 12D/I)	**Republicans** *N (%)*	**Dem./Ind.**[a] *N (%)*
MEDICAID EXPANSION	***Expanded*** *(elections in 21 of 28)*[c] 10R, 11 D	*Among winners in expansion states*	*N=10*	*N=11*
		Support status quo (Medicaid Expansion)	0 (0)	3 (36)
		Change/reverse (move towards private plan)	2 (20)	1 (9)
		Mentioned Medicaid but not expansion policy[b]	0 (0)	0 (0)
		No mention of Medicaid	8 (80)	7 (64)
	Not Expanded *(elections in 15 of 22)*[d]	*Among winners in non-expansion states*	*N=14*	*N=1*
		Support status quo *(no plans for expansion)*	4 (29)	0 (0)
		Change/reverse *(move from traditional ACA Medicaid expansion towards private plan or vice versa)*	2 (14)	1 (100)
		Mentioned Medicaid but not expansion policy[b]	2 (14)	0 (0)
		No mention of Medicaid	6 (43)	0 (0)
EXCHANGE[e]	***State Exchange*** *(elections in 19 of 23)*	*Among winners in states with state/partnership exchange*	*N=9*	*N=10*
		Supportive of current exchange	3 (33)	3 (30)
		Critical of current exchange *(e.g., poor implementation)*	1 (11)	1 (10)
		No mention of exchange	5 (56)	6 (60)
	Federal Exchange *(elections in 17 of 27)*	*Among winners in states with federal exchange*	*N=15*	*N=2*
		Supportive of current exchange situation	3 (20)	0 (0)
		Critical of current exchange *(e.g. move to state-based plan)*	0 (0)	1 (50)
		No mention of exchange	12 (80)	1 (50)

Note: [a] Of the 36 newly-elected governors, 24 are Republicans, 11 are Democrats and 1 is Independent (AK).
[b] Candidate may have mentioned exchanges or Medicaid expansion but provided no context linking these issues to federal law.
[c] States with elections that had expanded Medicaid in some form (n=21) as of Nov. 4, 2014 according to Kaiser Family Foundation (KFF): AR, AZ, CA, CO, CT, HI, IA, IL, MA, MD, MI, MN, NH, NM, NV, NY, OH, OR, PA, RI, VT
[d] States with elections that had not expanded Medicaid (n=15) as of Nov. 4, 2014: AK, AL, FL, GA, ID, KS, ME, NE, OK, SC, SD, TN, TX, WI, WY
[e] Exchange status as of Nov. 4, 2014 comes from KFF – states with their own exchange or a partnership exchange are grouped together.[98]

In terms of the 15 states that had not yet expanded Medicaid (non-expansion states) with elections, the topic of Medicaid came up far more often (over 60 percent) among these 30 candidates relative to those in states that had already expanded. A number of themes emerged based on candidates' statements for why expansion matters, with many Democrats emphasizing that it is what "taxpayers deserve" since they had already paid into the system through their taxes and also that "veterans" and "hard working families" were losing out on these coverage benefits.

As noted above, the incumbent party of the governor in these 15 states that had not yet expanded was entirely Republican and the party maintained this office in nearly all of these elections. Indeed, all but one of the Republican candidates were successful in their campaigns in non-expansion states. Half of the winning governors in these states mentioned Medicaid expansion on their websites. While most of them emphasized their justification to maintain a non-expansion status, this was not true for them all. In particular, Alaska, Wyoming and Tennessee (re-)elected governors who expressed their goals to move towards customized expansion options. For example, incumbent Governor Matt Mead who was re-elected in Wyoming stated on his website his opposition to "Obamacare" but willingness to "set parameters in the states" for "possibly expanding Medicaid the Wyoming Way".

In summary, when comparing the presence of Medicaid expansion among winners and losers in the Election, one can see that Democrats were more likely to discuss Medicaid expansion in non-expansion states but were also more likely to not be elected in these states, which were largely held by Republican incumbents (12 of the 15 states) (**Table 2.12**).

Table 2.12. ACA and Medicaid Expansion Mentions by Candidate, By Expansion Status & Election Outcome

	EXPANSION STATES WITH ELECTIONS *(n=21)*				NON-EXPANSION STATES WITH ELECTIONS *(n=15)*			
Candidate Electoral Outcome & Party	**Won**		**Lost**		**Won**		**Lost**	
	Rep (n=10)	Dem (n=11)	Rep (n=11)	Dem (n=10)	Rep (n=14)	Dem/Ind (n=1)*	Rep (n=1)	Dem/Ind. (n=13)
Explicit reference to ACA	4	4	4	3	11	1	1	5
Discussed Medicaid Expansion	2^	4	1	3	6	1	1	9
States to Watch (State, Governor-Party)	*Arizona (Ducey-R), Arkansas (Hutchinson-R), Pennsylvania (Wolf-D)*				*Alaska (Walker-I), Wyoming (Mead-R), Tennessee (Haslam-R)*			

Note: Rep=Republican, Dem=Democrat, Ind=Independent.
^Examples of newly-elected Republican governors in expansion states who are strongly against ACA and specifically mentioned Medicaid Expansion (Ducey (AZ) & Hutchinson (AK)).
*Alaska elected an Independent Governor - Bill Walker. For the ease of presentation, I include his campaign position along with Democrats to compare to Republican candidates.

B. Exchanges

Only a third of the governors elected in 2014 mentioned the ACA exchanges on their websites. When they did, they generally supported the current exchange setup in their state. Though winning candidates from both parties were critical the "rocky" implementation of the exchange rollout, they did not indicate a desire to drastically change their state's exchange situation (e.g., move from federal exchange to state exchange or vice versa). The only exception was Pennsylvania, where its new Democratic governor expressed interest to move towards a state-run exchange.

Other candidates that mentioned their intentions to move towards a state-based exchange, including Matt Michaud of Maine, were not elected in 2014.

> *"Immediately accept $3 billion in federal funds to cover 70,000 Mainers. B. Work in partnership with the federally facilitated exchange to increase insurance oversight and competition, especially for small business, and expand outreach to assist those eligible for premium tax credits to access them. C. Explore a state-run exchange, if needed and if funds are available." –Mike Michaud (D-ME), 2014*

2.6. DISCUSSION

Relying on an emerging source of political data – candidate's campaign websites – I provide evidence of the prominence and focus of health policy in both the 2012 and 2014 gubernatorial elections. These findings suggest that the majority of current governors in the United States – 45 of whom were analyzed in this study – grappled with health care in their campaigns and made strategic decisions to present their views on the ACA (or not) on this rising campaign medium.

Health Care as a Campaign Issue

When comparing the presence of policy issues across both campaigns, I find that healthcare has become more of a "stand-alone" issue over time across candidates vying for governor in the general election. Specifically, in 2012, health care was not within the top 5 list when ranked to other policy topics presented on the candidate's issues page. By 2014, however, it was the third most common issue mentioned by gubernatorial candidates on their "issues pages", ranking behind education and the economy (which were the top issues presented in 2012 as well). When evaluating the website more broadly, however, I find that the majority of candidates in both elections presented health policy issues on their websites, ranging from framing their concerns

regarding the ACA under the budget or discussing women's health issues (73% in 2012 versus 79% in 2014).

Though some suggested that the ACA would fade in prominence as an election issue, especially once the law was implemented, I provide evidence to the contrary in terms of gubernatorial engagement with this contentious policy issue.[100] Indeed, the primary focus of these health policy mentions, however, was predominantly the ACA or two of its key coverage provisions (Medicaid expansion and the exchanges) in both elections. Among all candidates, the ACA or its coverage provisions were mentioned by 50% of candidates in 2012, and even more so in 2014 (62%).

A partisan divide was apparent in terms of the positions that candidates took on the ACA, with Republicans overwhelmingly speaking about it negatively whereas Democrats were more likely to express favorable views towards it. This is not at all surprising given the ACA's politically polarized history.[41] Yet, these findings provide evidence of a lesser known partisan divide in terms of candidates from the different political parties mentioning the federal law explicitly on the campaign trail both prior to and following the implementation of Medicaid expansion and the health insurance exchanges. Specifically, in 2012, over 70% of Republicans mentioned the ACA whereas only 28% Democrats did so. In 2014, this gap closed somewhat, but Republicans were still more likely to specifically mention the law – which they overwhelmingly referred to as "Obamacare" – in their campaigns relative to Democrats.

Therefore, across both elections, these findings suggest that opponents of the ACA – who are more likely to refer to it as "Obamacare" than proponents – are also more vocal about it in their campaigns. And these are the very candidates who won the majority of the 47 elections of interest in this chapter (28 Republicans versus 19 Democrats). Moreover, incumbents fared remarkably well in their re-election campaigns across both years, and Republican incumbents were more likely to mention their opposition to the ACA relative to Democratic incumbents.

These findings resonate with previous literature on gubernatorial issue engagement suggesting that candidates will strategically focus on those issues that are salient to the public and that they believe will enhance their election chances.[40,82,101] However, though previous studies have shown that liberal governors devote more "agenda space" to health care in the past, these findings suggests that "issue ownership" of health care may be more nuanced for gubernatorial candidates in a post-ACA era since Republicans are far more vocal on their views towards health reform in these elections relative to Democrats.[44,81]

Medicaid Expansion and the Exchanges

The variability in winning gubernatorial candidates' mentions of state participation with ACA provisions, primarily with the controversial Medicaid Expansion, also is indicative of strategic campaign behavior.[84] Few winning governors from expansion states discussed this provision. Republican candidates appear to recognize that the ACA – as a whole – is unpopular among their constituency; therefore, they may not have wanted to associate themselves (or their predecessor from the same party) with taking steps to implement a key component of the federal law.[37,40] Additionally, it may have been unpopular strategy to campaign on taking away a tangible benefit

that has already been allocated and is popular among those who it is designed to benefit.[84,102] The winning Republican candidates from Arizona and Arkansas, however, challenged this notion as they stated their intentions to potentially reverse course on the Medicaid expansion status in their state. For Democrats, it is less surprising they avoided mentioning the ACA specifically – even when describing their views on Medicaid expansion – due to divided public opinion on the law.[37]

For non-expansion states, the topic of Medicaid was more frequently discussed among all candidates. Republicans (who generally have opposed the Medicaid expansion to date) won nearly all of these seats and mostly justified their states' non-expansion status, yet this study identified at least two winning candidates that expressed plans to explore Medicaid expansion options for their residents (Tennessee, Wyoming).[103] Similarly, the newly-elected Independent governor from Alaska and Democratic governor from Pennsylvania expressed plans to expand Medicaid.

These results also suggest that, at the time of the 2014 election, one would not have expected fundamental changes to ACA exchange infrastructure beyond Pennsylvania based on candidates' claims on their websites. However, only days after the election, the Supreme Court announced its decision to hear the *King v. Burwell* case about the availability of tax credits on the federal exchange, which has the potential to significantly affect the stability of the exchanges moving forward.[71,73] These findings suggest that the stakes for state-based decision-making regarding the ACA will only increase if the Supreme Court rules against the Obama Administration in this case.

Though the large share of current governors may be opposed to the ACA, they also recognize the inability to repeal the law at the state-level and thus must proceed with facilitating (or challenging) these key provisions insofar that the ACA is the law of the land. For example, as newly-elected Governor Asa Hutchinson (R-Arkansas) said:

> *"Ultimately, the only way to end this job killer is for Congress to repeal the law. The Arkansas legislature was handed a terrible program and had to choose how to deal with Obamacare. There was no good option for the state and there never will be unless Obamacare is repealed and replaced." –Asa Hutchinson (R-AR), 2014*

Looking Ahead

The prominence of the ACA and its key coverage provisions in this election, especially among the newly-elected Republican governors who expressed opposition to the law, augments their likelihood to invest political capital to shape the future of the ACA in their state. These sentiments at the state-level coupled with the Republican Party's strong performance in the November election at the congressional level have solidified a political landscape that favors continued debate on the federal law and a challenging implementation environment, especially in those states that remain hostile towards the law.[40,73]

While governors cannot act unilaterally to determine the course of the ACA's future in their state, they can serve as a useful facilitators or barriers to its implementation. Supporting this notion was the effort by Republican congressional members to write directly to governors and request that they take a role in the "repeal" movement by not enacting the healthcare provisions of Medicaid expansion or state-based exchange.[104] Yet, as the case study of the 2012 election

status suggests, even Republican governors who are ideologically opposed to the ACA are still seeking out state-based waivers to determine a path forward insofar that the law remains intact. This heightens the importance of monitoring activity around the state innovation waiver provision of the law, which will be possible starting in 2017, as states continue to grapple with the political realities of implementation.[105] This pattern of favorability towards state control (and thus variation in ACA implementation) among the "chief legislators" of the majority of the states has serious equity implications for health policy both for access and quality of healthcare.

Though the ACA was the dominant issue in the healthcare content on gubernatorial candidates' campaign websites, a few topics emerged across both political parties that may be spared of the politicized rhetoric that is characteristic of contemporary ACA debates. These include improvements to mental health care, addressing provider shortages or needs in the states, and potentially efforts to reward "quality" over quantity of care. Nonetheless, these issues do not come up nearly as often as concerns or commitments to resolve problems regarding health care costs/affordability. While these common health system problems may be identified across the governors regardless of political party, the debate seems to remain alive and well in terms of the ACA's ability to mitigate or exacerbate these health policy problems between Republican and Democratic governors.

From a methodological standpoint, this website analysis adds to previous studies that examine issue emphasis by sitting governors through their state speeches.[44,81] It suggests that campaign websites may be a useful, complementary source for gathering information on gubernatorial candidates' views related to healthcare, especially as the issue remains salient to the public. As

such, studies that wish to monitor gubernatorial issue engagement with the ACA may find this useful in the forthcoming 14 gubernatorial elections taking place in 2015/2016. Moreover, policymakers who may wish to get a sense of a direction that a state may be taking in the future may wish to examine these campaign statements systematically, especially among incumbents who may run for re-election.

2.7. CONCLUSION

Governors are critical stakeholders and influences of the health care agenda in their state. This is particularly true in the era of a politicized health reform implementation period, which relies heavily on state participation and support. The campaign positions expressed by the 47 winning governors examined in this analysis suggest that many of them – especially Republicans – are willing to spend political capital to shape the ACA's future in their state insofar that the federal law remains intact.

Chapter 3

Changes in Hospital-Physician Affiliations and Impact on Quality of Care*

**A version of this chapter has been submitted for publication (co-authors: Orav, Cutler and Jha). Please do not circulate.*

3.1. INTRODUCTION

Healthcare providers are increasingly facing demands to lower costs and enhance quality of care. Improving integration between hospitals and physicians, such as through hospital employment of physicians, has been viewed as one policy solution that has the potential to achieve these aims. Having a physician workforce that is tightly integrated with the hospital can, for example, make it easier to incentivize clinicians to focus on quality metrics, share common information systems, and comply with clinical guidelines.[106–109] There is growing evidence that these kinds of "tightly integrated" or hospital-physician employment relationships have increased in recent years, and advocates believe that such a trend should lead to greater care coordination, more closely aligned incentives, and ultimately, better patient care. [109–117]

Historically, hospitals were viewed as the "workshops" of physicians, and efforts to employ doctors were discouraged – if not prohibited – by medical societies to prevent the potentially negative consequences of reduced autonomy on the patient-physician relationship.[118] This divide helped perpetuate payment models where hospitals and physicians are reimbursed separately, such as in the dominant fee-for-service system that is faulted with promoting quantity over value.[119] The rise of managed care in the 1990s facilitated opportunities for hospitals and physicians to reconsider this independence; however, attempts at vertical integration between these providers during this era were rarely met with financial success and many hospitals subsequently divested themselves of their previously acquired physician groups.[118,120] In spite of this failure, there is growing evidence that hospitals are again acquiring physician practices and entering into employment arrangements with physicians.[109–114,115]

There are competing theories regarding the impact of vertical integration between hospitals and physicians on both cost and quality in health care.[111] Some argue that such integration can simultaneously improve quality and lower costs by improving care coordination, while others believe that this integration is motivated more by the prospect of increasing provider market power and prices.[121] A recent survey of physician perceptions on the effects of greater physician employment also suggests mixed opinion on whether or not this trend is beneficial for patient care. For instance, the 2012 Physicians Foundation survey showed that more than 7 in 10 of current physicians say they believe hospital employment will erode the physician-patient relationship and quality of care; less than a quarter agreed with a statement that hospital employment physicians is a positive trend likely to enhance the quality of care and lower costs.[122] When stratifying the respondents by affiliation type, however, outlooks on the ability of vertical integration to improve value in healthcare are more optimistic among those physicians who are in employment relationships.[122] Overall, while advocates believe that this rise of vertical integration between hospitals and physicians may help lead to improvements in quality of care[116,117] – and current provider responses to the health reform law may only continue to foster its growth[123] – the evidence to date is mixed on what greater vertical integration between hospitals and physicians means for healthcare spending and, especially, for quality of care.[113,118,121,124–127] Indeed, the literature on this topic has been described as "thin, inconsistent and scattered.[109]

Given the salience of this topic coupled with current national efforts to hold hospitals accountable for providing high quality care, I aimed to answer three key questions using contemporary, longitudinal national data at the hospital-level – for which there is little empirical

work to date – for evaluating the impact of vertical integration on quality of care: first, what proportion of acute-care hospitals in the U.S. report having employment relationships with at least a subset of their physicians and how much has that changed over the past decade? Second, what types of hospitals have chosen to enter into these employment relationships with physicians over the past decade and how do they differ from hospitals that have not? And finally, what is the aggregate clinical consequence of such a switch on the quality and efficiency of patient care at the hospital level?

3.2. METHODS

Data

Data for this national study come from a number of sources. First, I used data from the 2003-2012 American Hospital Association (AHA) questionnaire to collect information regarding hospital characteristics and hospital-physician affiliation status. Second, I used national Medicare data (MedPAR) from 2002-2012 to calculate hospital-level performance on a variety of quality and efficiency indicators, including risk-adjusted mortality rates, risk-adjusted readmission rates, and risk-adjusted lengths of stay for common medical conditions (acute-myocardial infarction (AMI), cardiac heart failure (CHF) and pneumonia (PN)). For these analyses, the sample was limited to Medicare beneficiaries enrolled in the fee-for-service program who were 65 years of age or older. Third, I used Hospital Compare data from 2007-2012 to assess overall patient experience from the Hospital Consumer Assessment of Healthcare Providers System (HCAHPS) survey.

Inclusion Criteria for Population Studied

Basic inclusion criteria are hospitals that are: 1) non-federal, 2) designated as a general medical & surgical service type, and 3) located in the 50 states and the District of Columbia in the United States.

Variables

I examined four outcome variables related to hospital performance. The first was hospital-level, risk-adjusted 30-day mortality rates for three common and costly conditions that have garnered a great deal of policy attention in recent years: acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia (PN). If having employed physicians is useful for greater compliance with guidelines and closer integration of hospital and ambulatory care, one might expect to see the biggest effects for these conditions. Next, I examined risk-adjusted 30-day readmission rates and risk-adjusted lengths of stay for each of these three common medical conditions. To calculate the hospital-level rates for each of these outcomes, I used the Elixhauser risk-adjustment scheme, which is commonly used in administrative data and accounts for differences in patient risk using comorbidities listed in the claims data.[128] Though I evaluated each of the outcomes individually and present overall findings for each, I simplify presentation of the yearly hospital group performance using a composite of these outcomes (constructed using indirect standardization – a widely-employed method that allows for combination of multiple measures).[129,130] Finally, I examined if hospital employment of their physician workforce was associated with subsequent improvements in patient experience using the hospital's performance on the HCAHPS metric: percent of all adult patients giving high satisfaction scores (9 or 10 on a ten-point scale).

I was also interested in key structural variables, including size, teaching status, proportion of patients insured by Medicare or Medicaid, that might be associated with hospitals switching to physician employment and the outcomes of interest, and obtained these potential confounding variables from the AHA database. Additionally, I used the Rural Urban Commuting Area codes to capture urbanization of the community in which the hospital was located.

Independent Variables

I first categorized all hospitals into three main groups to simplify presentation of trends: Employment Affiliation, Contractual (Non-Employment) Affiliation and No Affiliation, using data from the AHA Annual Questionnaire (**Table 3.1**). This grouping procedure follows previous theoretical and empirical work on vertical integration at the hospital level.[124,131]

Specifically, within the AHA Annual Questionnaire, hospitals can identify whether or not their hospital has entered into contractual or ownership-based arrangements with any physicians across 8 domains. These are dichotomous variables, where a hospital indicates that yes (1) they have formed this particular arrangement with physicians or (0) that they have not. In cases where hospitals indicate "no" (0) for all categories, I consider these hospitals to have no integration affiliations with physicians ("no affiliation").

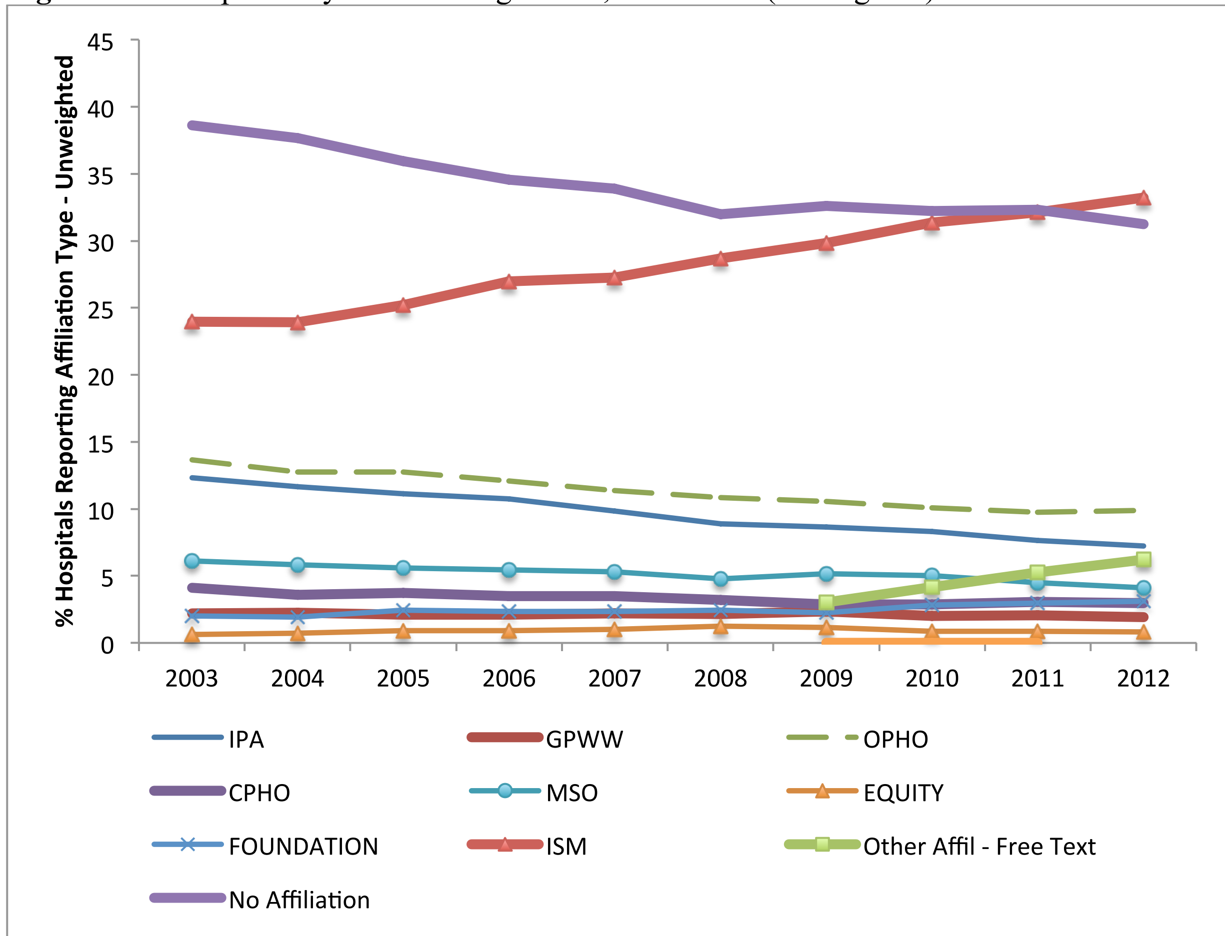
Table 3.1. AHA Descriptions of Hospital-Physician Arrangements[132]

AHA Category	Definition (AHA Survey)	Group Categorization
Independent practice association (IPA)	AN IPA is a legal entity that holds managed care contracts. The IPA then contracts with physicians, usually in solo practice, to provide care either on a fee-for-services or capitated basis. The purpose of an IPA is to assist solo physicians in obtaining managed care contracts.	Contractual (Non-Employment) Affiliation
Group practice without walls (GPPW)	Hospital sponsors the formation of, or provides capital to physicians to establish, a "quasi" group to share administrative expenses while remaining independent practitioners.	Contractual (Non-Employment) Affiliation
Open physician-hospital organization (OPHO)	A joint venture between the hospital and all members of the medical staff who wish to participate. The PHO can act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary services projects, or provide administrative services to physician members.	Contractual (Non-Employment) Affiliation
Closed physician-hospital organization (CPHO)	A PHO that restricts physician membership to those practitioners who meet criteria for cost effectiveness and/or high quality.	Contractual (Non-Employment) Affiliation
Management services organization (MSO)	A corporation, owned by the hospital or a physician/hospital joint venture, that provides management services to one or more medical group practices. The MSO purchases the tangible assets of the practices and leases them back as part of a full-service management agreement, under which the MSO employs all non-physician staff and provides all supplies/administrative systems for a fee.	Contractual (Non-Employment) Affiliation
Integrated salary model (ISM)	Physicians are salaried by the hospital or another entity of a health system to provide medical services for primary care and specialty care.	Employment Affiliation
Equity Model (EM)	Allows established practitioners to become shareholders in a professional corporation in exchange for tangible and intangible assets of their existing practices.	Employment Affiliation
Foundation Model (FM)	A corporation, organized either as a hospital affiliate or subsidiary, which purchases both the tangible and intangible assets of one or more medical group practices. Physicians remain in a separate corporate entity but sign a professional services agreement with the foundation.	Employment Affiliation
Other, please specify*	**Author note:* This free text description was added to the AHA questionnaire in 2009. These data are incomplete among the minority of hospitals that select this option. Specifically, after applying the exclusion criteria, only 139 of 4596 total hospitals in 2009 and then 243 of 4606 hospitals in 2011 selected this "Other" option. Since there are relatively few hospitals who select this option and I do not have much information on what exactly this "Other" affiliation type means, I excluded these "other" affiliations from the possible pool of control hospitals between 2009 and 2011.	Excluded

Note: All remaining hospitals that selected none of these hospital-physician affiliations were considered "unaffiliated" in this analysis.

In **Figure 3.1**, I plot the percentage of hospitals each year that indicate being in each of the individual arrangements. This shows how the "integrated salary model" hospital constitutes the dominant share of hospitals categorized in the employment affiliation type.

Figure 3.1. Hospital-Physician Arrangements, 2003-2012 (unweighted).



As noted above, I classified hospitals into three main groups to summarize these patterns over time, which is described further in the results section of this chapter. I use these designations to inform the classification of "switcher" hospitals, which are used as the treatment group for the key differences-in-differences analysis:

- *Category 1. Employment Affiliation*
    - *Definition:* Hospital indicated that they were in the: Integrated Salary Model (ISM), Equity (EM) and/or Foundation models (FM).
        - This employment group is based on the hospital-ownership categorization described in Bazzoli et al. 1999, where they defined FM, EM and ISM as the arrangements "in which physician practices were owned by hospitals and physicians were organized in subsidiaries.").[131]
- *Category 2. Contractual, Non-Employment Affiliation*
    - *Definition:* Hospital indicated that they were in any of the remaining models, but not in the ISM, Equity or Foundation models.
- *Category 3. No Affiliation*
    - *Definition:* Hospitals did not select any of the 8 affiliations listed on the AHA questionnaire (e.g., these may be physicians with admitting privileges at the hospital but have no contractual or ownership affiliation with the facility that extends beyond the traditional medical staff model).[124]

For the minority of hospitals that indicated multiple arrangements (less than 25% in 2010, for example), they are categorized as having the tightest affiliation form. Since this hospital-level analysis did not permit me to ascertain what types of physicians were in each specific model or arrangement (e.g., IPA or EM), I did not exclude hospitals from the employment group that indicated additional affiliations beyond the ISM, FM, or EM designations. In other words, if a hospital indicated being in both an IPA and ISM, it was categorized as being in the "employment

affiliation" group. This classification method follows previous theoretical and empirical work exploring the dynamics of these "hybrid" strategy hospitals.[113,133]

Panel Construction

To construct the analytical dataset, I constructed a panel of all hospitals that converted into the employment affiliation between 2003 and 2011 (i.e., a hospital reporting that it was not in an employment relationship in 2005 but then does so in 2006 is designated a "switcher" and the "converting year" is 2005). The procedure for identifying potential control hospitals (those that did not have an employment model in the base year and did not switch during the converting year) was similar. I then grouped all hospitals that switched into an employment model in a given Hospital Referral Region (HRR) to all possible control hospitals (those that had not made such a switch) within the same HRR in order to account for unobservable characteristics of the local healthcare market. Matched control hospitals were identified for nearly all (98.0%) cases of switching that occurred in the analytic sample.

Analysis

I first plotted the proportions of hospitals in each group of interest (Employment Affiliation, Contractual (Non-Employment) Affiliation and No Affiliation) from 2003 through 2012, accounting for survey non-response, to illustrate the changing trend of physician-hospital affiliations over time. Next, and given that the primary predictor for subsequent analyses is whether or not a hospital "switched" into an employment-type arrangement, I then compared the characteristics of the switcher hospitals with those hospitals that never switched during the study period. I examined the structural differences (e.g., size, teaching status) of these two groups of hospitals using chi-squared and t-tests as appropriate. Further, in a secondary analysis, I

compared these structural differences with those hospitals that had entered the observation period in 2003 as already employing physicians at their site (and thus were excluded from the analysis since I focused on those hospitals that more recently switched into this model).

Next, to help visualize the subsequent effects on aggregate hospital-level clinical outcomes of switching, I estimated a series of linear fixed effect models, adjusting for hospital size, profit status, teaching status, rurality, percent Medicare patients, percent Medicaid patients and calendar year. I then obtained predictive margins for switchers and non-switchers within each time period, including the year of conversion (*t=0*), ranging from two years prior to conversion (*t-2*) and up to three years following switching into an employment model (*t+3*). In the results, I show the plots from the adjusted models. Further, I provide the unadjusted plots of all composite risk-adjusted outcomes that do not take these additional hospital characteristics into account.

Finally, I sought to identify the association between hospital conversion into the employment affiliation and each of the four outcomes of interest. The primary approach was a hospital-level difference-in-differences analysis to assess if hospitals that convert to employment status improve in their hospital performance after the switch occurred, relative to their matched controls in the same HRR that did not convert. In the regression model for each outcome, the independent variables were status of a hospital switching into an employment-type model ("switching status") (yes/no), a pre-post indicator to denote if the outcome data came from within 2 years before the switch (post=0) or within 3 years after the switch (post=1), an interaction between switching status and post (switcher*post), and then a variable for calendar year, matched group, and other covariates (size, profit status, teaching status, rurality, percent

Medicare patients, and percent Medicaid patients). The coefficient of the interaction term (the "difference-in-differences" coefficient) captures the impact of switching into hospital employment on the outcome of interest, controlling for the covariates noted above. The primary empirical test is whether or not the coefficient of the interaction term is different from zero. In these analyses, I excluded the actual year of conversion from the analysis (t) and considered this a washout year since it was not possible to determine at which point during the survey year that a hospital may have made this transition to employing physicians.

I completed these analyses using Stata, version 13.0. All regression analyses relied upon the *xtreg* package to fit a random effects regression model, and then I adjusted for the within-matched-group correlation by including fixed effects for each matched group and robust standard errors. I completed a variety of sensitivity analyses, including allowing for random effects as well as excluding calendar year as a covariate. These results were qualitatively very similar and are not presented. Two-tailed p-values of < 0.05 were considered to be significant. Approval for this study was obtained from the Office of Human Research Administration at the Harvard School of Public Health.

Limitations

Though this is the first contemporary analysis of the impact of vertical integration on quality of care at the hospital level, there are important limitations to this study. First, the outcomes I examined are primarily for an older patient population (Medicare beneficiaries aged 65 and above); therefore, whether these findings would hold true for patient outcomes for those under 65 is unclear. Further, these findings may not be generalizable to those hospitals that may

transition into vertical arrangements but draw heavily upon a commercially-insured population of patients. However, there is little reason to believe that hospitals, after switching to employment model, would improve care for one group of patients but not another. Also, it is timely to focus on implications for the Medicare program given its critical role in the U.S. healthcare system as both a payer of healthcare services as well as regulatory agency that is capable of setting national policy related to quality of care (e.g., penalties for preventable readmissions). Second, though this analytic approach aimed to maximize power to detect clinically meaningful differences, it is possible that small differences could have missed. Third, while the observation period of this study was designed to examine patient outcomes up to three years after the switch, it may take longer to have a beneficial effect on these particular clinical metrics. Fourth, though this study's outcomes are useful to better understand what this change in the marketplace may mean for patients, it is possible that other outcomes such as total costs and physician satisfaction, which are not available in these data sources, would be useful to examine in this context.[122] Lastly, while I used the best national data available to identify which hospitals have entered into these arrangements, I am limited to observing these switches at the hospital-level as opposed to what is happening specifically among the physicians at each site. As such, there is likely variation around my key measure of integration as hospitals may differ in their interpretation of employment or have a spectrum of arrangements at their site; it is not possible with this dataset to specifically comment on the types of physicians that are entering into this agreement (e.g., all primary care or all specialists, or a mix).

Given this limitation, I aimed to obtain an approximation of how many hospital-affiliated physicians were in an employment-type arrangement. I therefore calculated the sum of the

values entered for number of physicians in the employment designation (i.e., ISM, Equity and Foundation models) divided by the sum of all 8-specific categories (i.e., IPA through ISM). When including the “Other” category, the overall mean percentage of physicians in the employment model among all affiliated physicians at a given hospital is relatively unchanged (74.8%). I provide the mean percentage of affiliated physicians that are in the employment or closely-related model as reported by “switcher” hospitals in **Table 3.2** across converting year and overall.

Table 3.2. Mean Percentage of Hospital-Affiliated Physicians in Employment Model Among Switcher Hospitals

Converting Year*	Number of Unique Switcher Hospitals	Mean Percentage of Physicians in Employment Model (ISM, Foundation, Equity) (%)
2003	152	75.0
2004	178	70.9
2005	151	76.4
2006	113	76.4
2007	129	77.4
2008	114	78.1
2009	130	70.2
2010	135	81.8
Mean Percentage of Physicians in Employment Model (2003-2010)		75.8

Note: For converting years 2008-2010, I excluded the “Other” category, which was introduced as a new entry option in the AHA questionnaire in 2009. When including the “Other” category to obtain these estimates, however, the overall mean percentage of physicians in the employment model within the unique switching hospitals remains relatively unchanged (74.9%).

While a useful denominator for assessing how many affiliated physicians are within the employment model, the summation of the “number of physicians column” does not necessarily reflect the true denominator of all physicians with privileges at a particular hospital. Market trends would suggest a broad spectrum of arrangements at some hospitals, where they employ a subset of physicians while others may be unaffiliated and not categorized by any of these

integration options.[134] Fortunately, the AHA has recently issued updates to its questionnaire as of 2011 that may allow future research in this area to examine specific employment arrangements by type of provider (e.g., primary care, emergency department, specialists) within a new section titled "Privileged Physicians". Though I am limited to only one year of comparison data, there was a high correlation (r>0.70) between this study's employment variable (combination of ISM, equity and foundation) and this new measure to capture the total number of employed physicians among all physicians with privileges at a given hospital.

In spite of these concerns, it is important to note that these AHA variables have been widely used in examining issues around vertical integration and the changing relationships between hospitals and physicians.[109,113,121,124] Given that the primary focus of this study is to examine hospitals that recently entered into this employment relationship with at least a subset of their physicians and observe if they witnessed improvements in their performance of quality of care, this approach was deemed most appropriate. And since I observe the proportion of hospitals entering into these particular employment arrangements increasing over time, it is important to determine if such a trend is associated with improvements in quality at the hospital level.

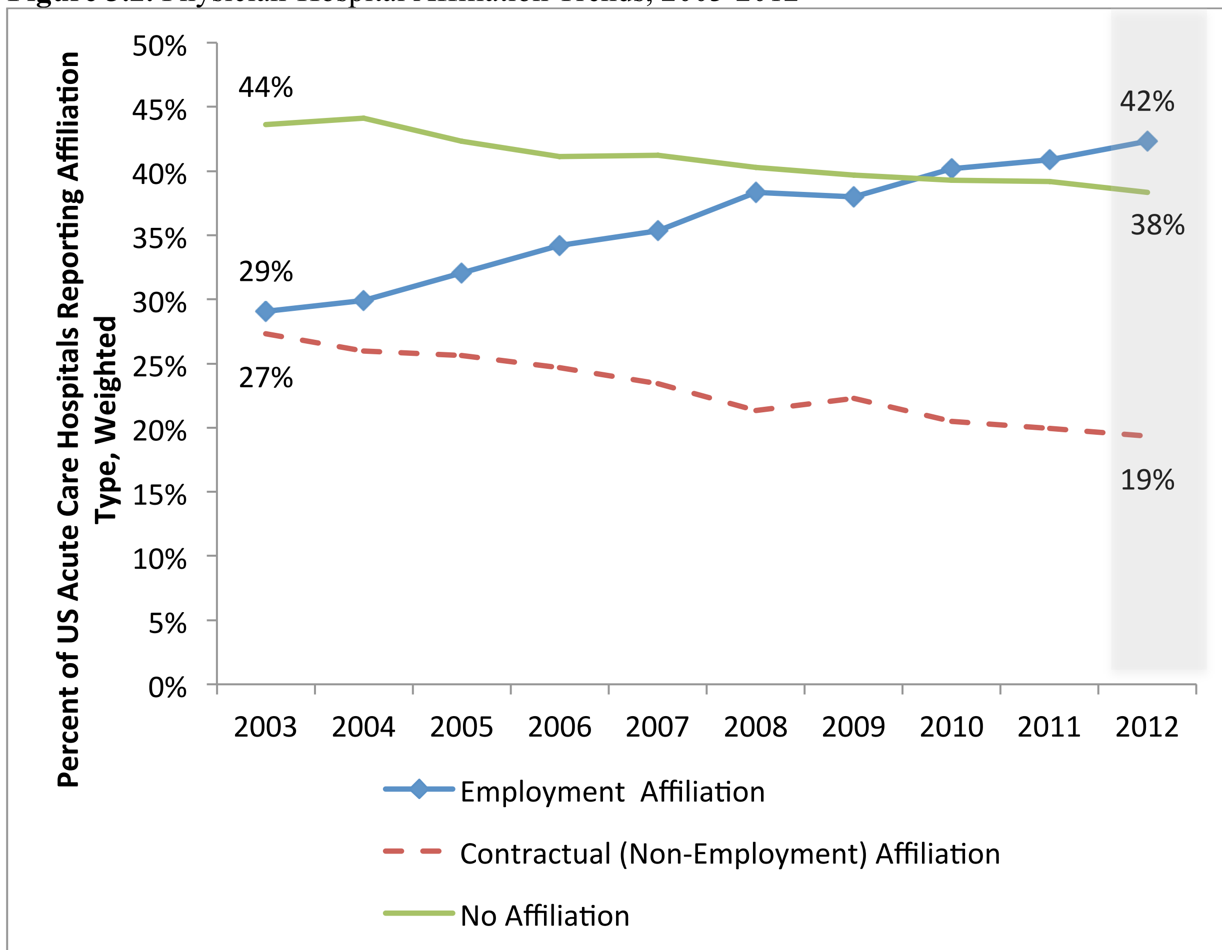
3.3. RESULTS

Trends in Hospital-Physician Affiliations

In 2003, 44% of U.S. hospitals were "unaffiliated", having no affiliations with physicians beyond the traditional medical staff model[124] while 29% reported having an employment relationship with part of their physician workforce and 27% reported having a looser, contractual affiliation **(Figure 3.2)**. By 2012, the proportion of hospitals reporting having either an

unaffiliated relationship or the non-employment affiliations dropped substantially to 38% and 19%, respectively, while 42% of hospitals reported having employment arrangements with physicians. From 2009 onward, employment became the most prevalent hospital-physician affiliation model that U.S. hospitals form with at least a subset of their physicians.

Figure 3.2. Physician-Hospital Affiliation Trends, 2003-2012



Note: Categories are described further in Table 3.1. These estimates have been weighted to account for survey non-response to the annual AHA questionnaire (approximately 10-15% of hospitals each year). To account for survey nonresponse, I estimated a logistic regression model based on key hospital characteristics (size, teaching status, profit status, RUCA level and region) to determine the likelihood of responding and weighted these three affiliation categories accordingly. I include 2012 data to show this trend, but my subsequent analyses include hospitals switching only between 2003 and 2011 in order to preserve at least one year of observation for the outcomes of interest, which I only have through 2012.

Comparison of Hospitals That Convert To Employment Status Versus Non-Switchers

Between 2003 and 2011, I observed a total of 1166 switches (average of 145 per year) from 1102 unique converting hospitals (a minority of hospitals switched more than once) (**Table 3.3**).

Table 3.3. Overview of Analytic Dataset for Primary Analysis, by Switching Variable

Converting Year	Switches (employmentswitch=1)*	Matched Treatment Hospitals by Year (employmentswitch=0)
2003	152	1,237
2004	178	1,159
2005	157	978
2006	118	873
2007	144	964
2008	123	896
2009	142	951
2010	152	782
Total	**1166**	**7,840**

Note: *The count represents the total number of switches, and not necessarily unique switchers (n=1102 unique hospitals). A sensitivity analysis was done to compare the results and no substantive differences were noted. Converting Year has a different meaning relative to "calendar year". For instance, the "converting year" of 2004 indicates that a hospital reported not being in an employment or closely-related model within the AHA questionnaire in 2004, but indicated being in this model within the next year (2005).

Relative to those hospitals in 2003 that were not already in an employment model and never converted into these models during this period, these converting hospitals differed in a number of ways: converting hospitals were more often large (12.0% versus 6.3%), more often major teaching hospitals (7.4% versus 3.9%), and less often for-profit (8.9% versus 21.8%, all p-values <0.001) (**Table 3.4**). There were no meaningful differences in the proportion of Medicare or Medicaid patients between these two groups.

Table 3.4. Characteristics of hospitals that switched to physician employment versus those that did not between 2003 and 2011

		Switcher Hospitals (N=1,102)	**Never Switchers (N=2,458)**	**P-Value**
		%	**%**	
Hospital Size	Small	47.1	47.9	<0.001
	Medium	41.0	45.8	
	Large	12.0	6.3	
Hospital Region	Northeast	12.4	12.5	<0.001
	Midwest	31.5	24.8	
	South	38.0	42.2	
	West	18.1	20.6	
Teaching Hospital Status	Major teaching	7.4	3.9	<0.001
	Minor teaching	17.0	12.7	
	Not teaching	75.7	83.5	
Profit Status	For profit	8.9	21.8	<0.001
	Private non-profit	67.5	54.6	
	Public	23.6	23.6	
Rural Urban Commuting Area (RUCA)	Urban	43.3	47.0	0.001
	Suburban	4.8	5.5	
	Large rural town	20.7	15.2	
	Small town/Isolated rural	31.2	32.2	
Percent of Medicare Patients (SD)		48.5 (0.4)	48.0 (0.3)	0.26
Percent of Medicaid Patients (SD)		16.3 (0.3)	16.3 (0.2)	0.81

Further, I compared these groups of hospitals to those that entered the observation period in 2003 already having an employment arrangement. In **Table 3.5**, I summarize this comparison between 1) "switchers" (those hospitals that switched into the employment model between 2003 and 2011); 2) "never switchers" (those hospitals that entered the observation period in 2003 as not employed and never switched into the model through the observation period); and 3)

"already employed" (those hospitals that were already in an employment model as of 2003, the first year of AHA data that I used). I found that the "already employed" group looks most similar to switcher hospitals, though there are some differences in location of switching (e.g., the South and large-rural towns) between the already employed group (as of 2003) and future switchers between 2003 and 2010.

Table 3.5. Comparison of Unique Switchers into Employment Model versus Already Employed as of 2003 versus Never Switchers

		Switcher Hospitals (N=1,102)	**Already Employed (N=1,043)**	**Never Switchers (N=2,458)**	**P-Value**
		%	**%**	**%**	
Hospital Size	Small	47.1	44.7	47.9	<0.001
	Medium	41.0	42.1	45.8	
	Large	12.0	13.2	6.3	
Hospital Region	Northeast	12.4	16.3	12.5	<0.001
	Midwest	31.5	39.3	24.8	
	South	38.0	28.6	42.2	
	West	18.1	15.8	20.6	
Teaching Hospital Status	Major teaching	7.4	9.4	3.9	<0.001
	Minor teaching	17.0	20.2	12.7	
	Not teaching	75.7	70.4	83.5	
Profit Status	For profit	8.9	5.7	21.8	<0.001
	Private non-profit	67.5	69.1	54.6	
	Public	23.6	25.2	23.6	
Rural Urban Commuting Area (RUCA)	Urban	43.3	45.2	47.0	<0.001
	Suburban	4.8	3.3	5.5	
	Large rural town	20.7	15.9	15.2	
	Small town/Isolated rural	31.2	35.6	32.2	
Percent of Medicare Patients (SD)		48.5 (0.4)	49.2 (0.4)	48.0 (0.3)	0.07
Percent of Medicaid Patients (SD)		16.3 (0.3)	15.5 (0.3)	16.3 (0.2)	0.10

Clinical Consequence of Switching Into an Employment Model

When comparing hospitals that converted to an employment relationship relative to hospitals that did not do so in the same hospital referral region, I found no association between conversion and subsequent changes in mortality, readmissions, lengths of stay, or patient satisfaction.

To illustrate these findings, I first provide the unadjusted and corresponding adjusted composite results for each outcome (**Figures 3.3 – 3.10**). For the raw composite outcomes, I plot the unadjusted mean performance of switchers and matched non-switchers in the same HRR for all composite risk-adjusted outcomes (**Figures 3.3, 3.5, 3.7, 3.9**). For the adjusted composite outcomes, I plot the predictive margins for each time period relative to the year of conversion come from linear estimates of fixed effect models at the matched-group level, which were adjusted for hospital size, profit status, teaching status, rurality, percent Medicare patients, percent Medicaid patients and calendar year (**Figures 3.4, 3.6, 3.8, 3.10**). For all figures, switchers are defined as those hospitals that converted to an employment model in a given year. They are matched with non-switchers in the same HRR at the point of the converting year. On the x-axis, “t” refers to the year that the switch occurred, with “t-2” referring to two years prior to the switch and “t+3” referring to 3 years following a switch into an employment model.

Mortality

Figure 3.3. Unadjusted Composite Risk-Adjusted Mortality Rate Between Switchers and Matched Non-switchers Relative to Year of Switch (t)

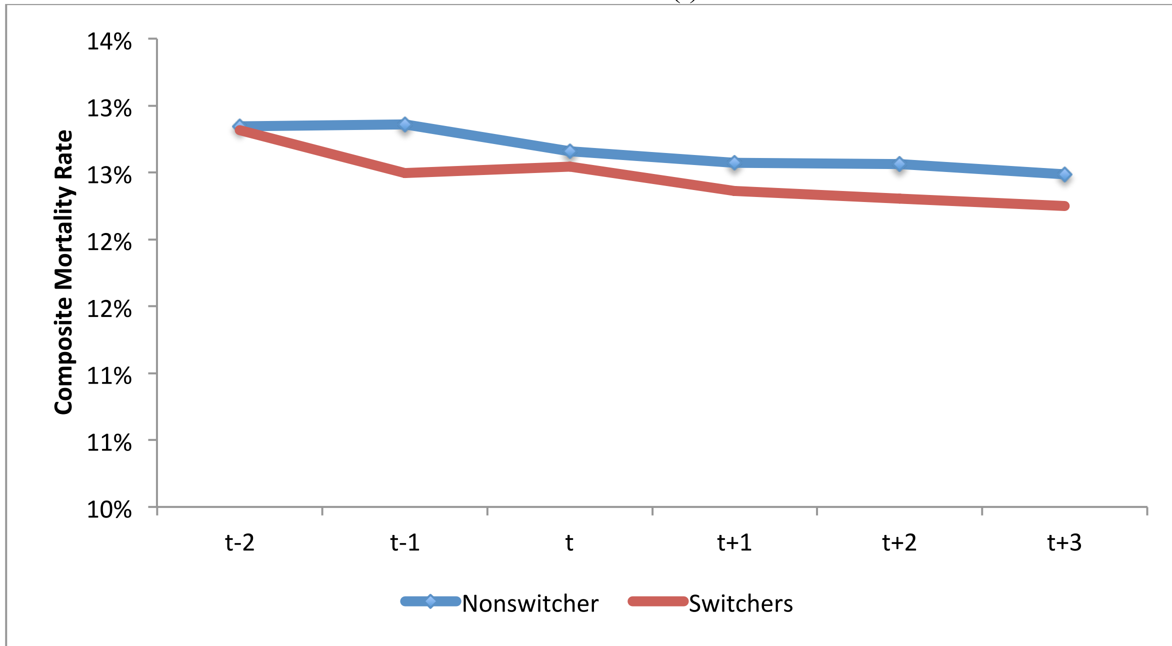
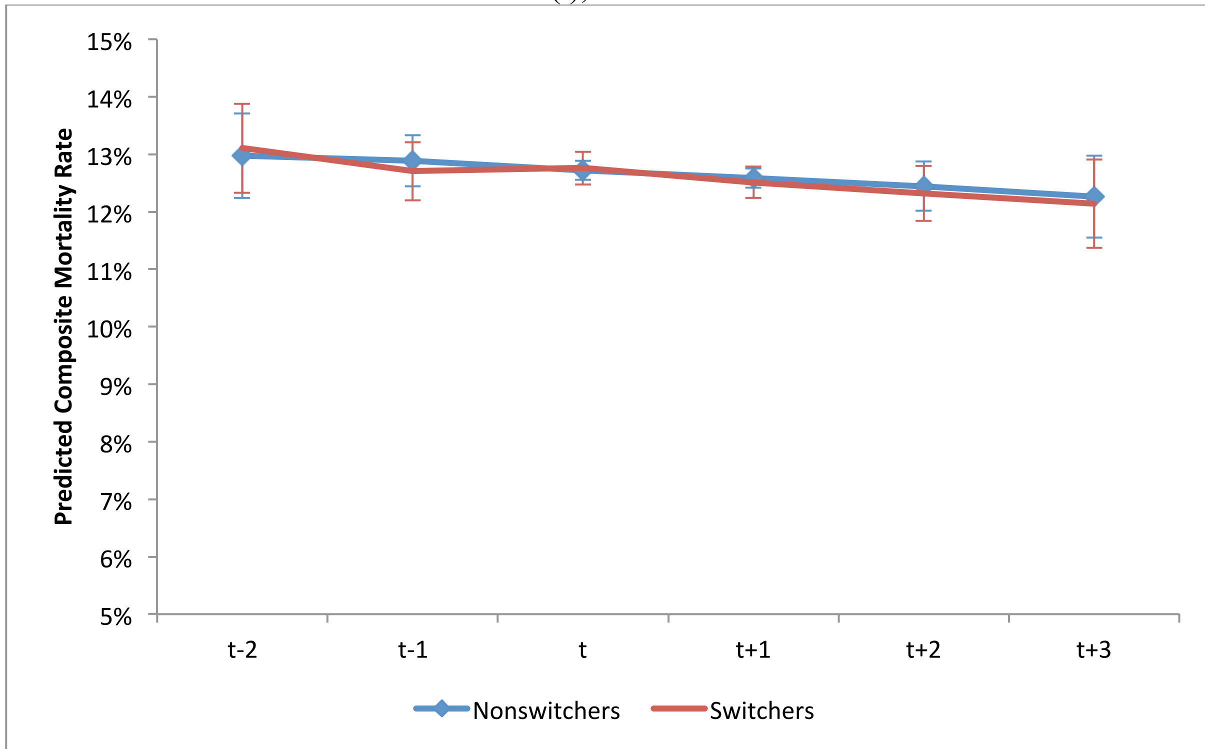


Figure 3.4. Predictive Margins of Composite Mortality Rate between Switchers and Matched Non-switchers Relative to Year of Switch (t), with 95% Confidence Intervals



30-Day Readmissions

Figure 3.5. Unadjusted Composite Risk-Adjusted Readmission Rate Between Switchers and Matched Non-switchers Relative to Year of Switch (t)

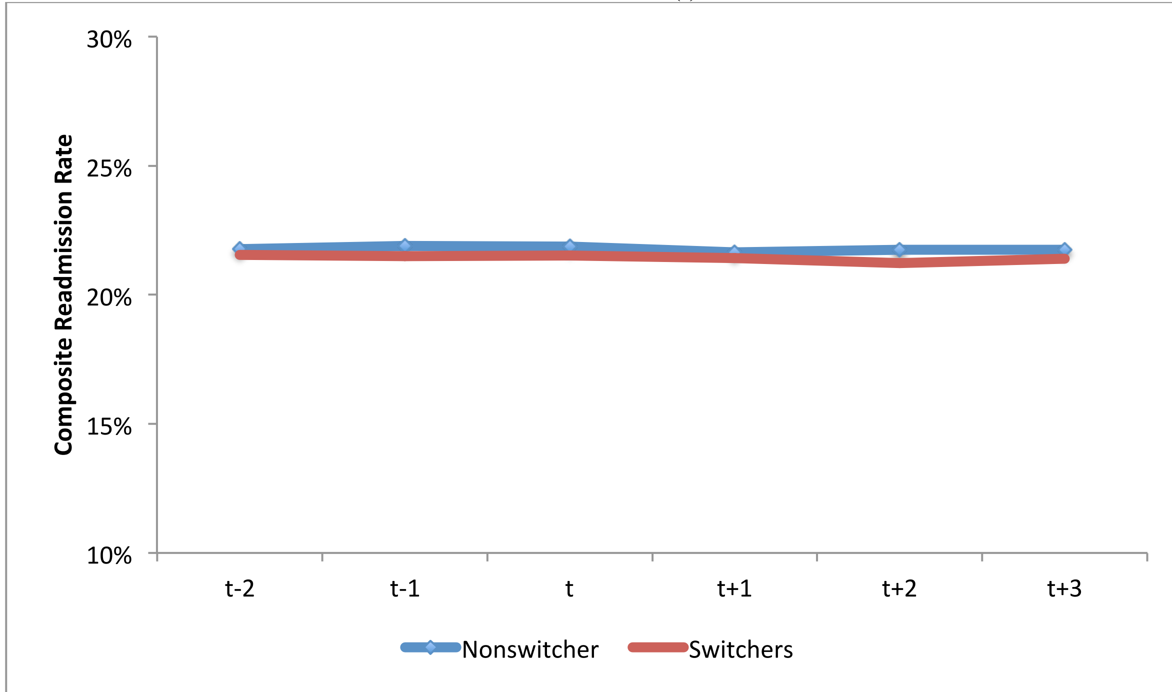
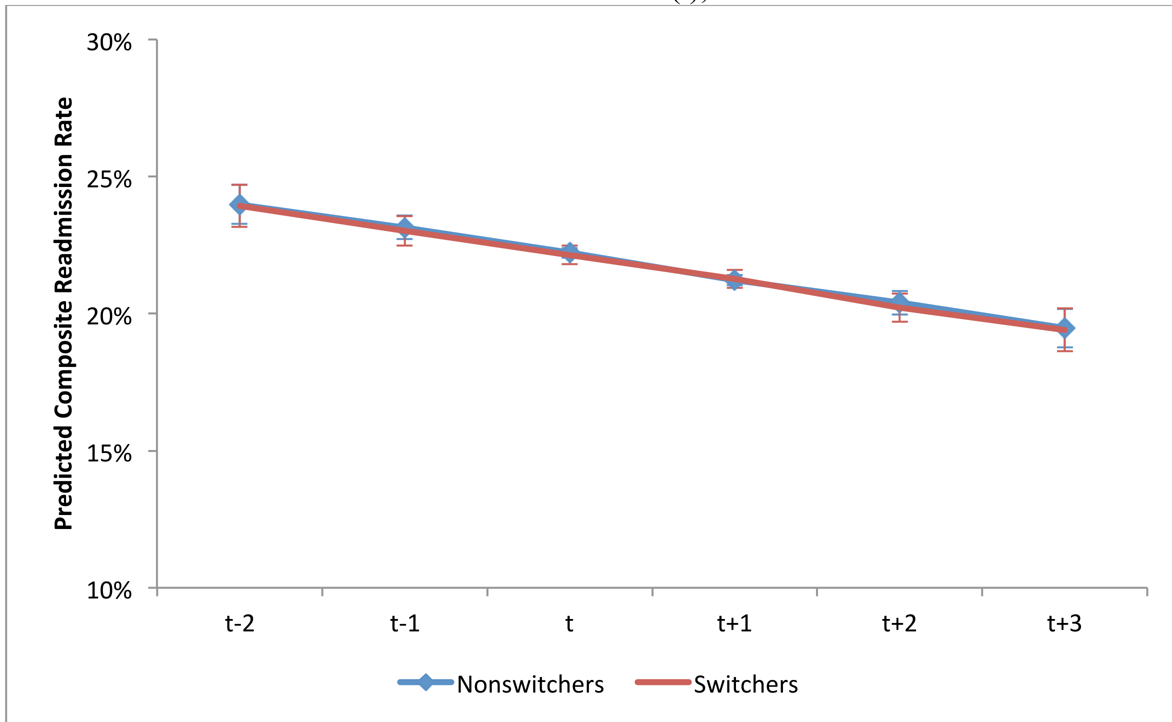


Figure 3.6. Predictive Margins of Composite Readmission Rates between Switchers and Matched Non-switchers Relative to Year of Switch (t), with 95% Confidence Intervals



Length of Stay

Figure 3.7. Unadjusted Composite Risk-Adjusted Length of Stay Between Switchers and Matched Nonswitchers Relative to Year of Switch (t)

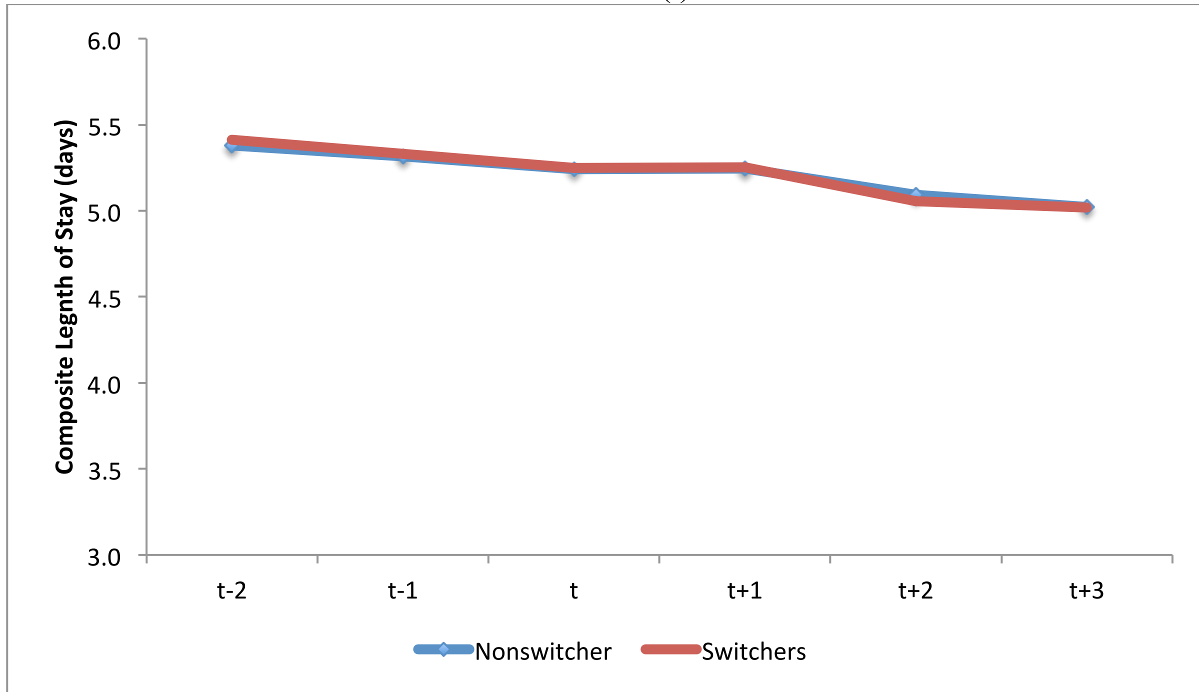
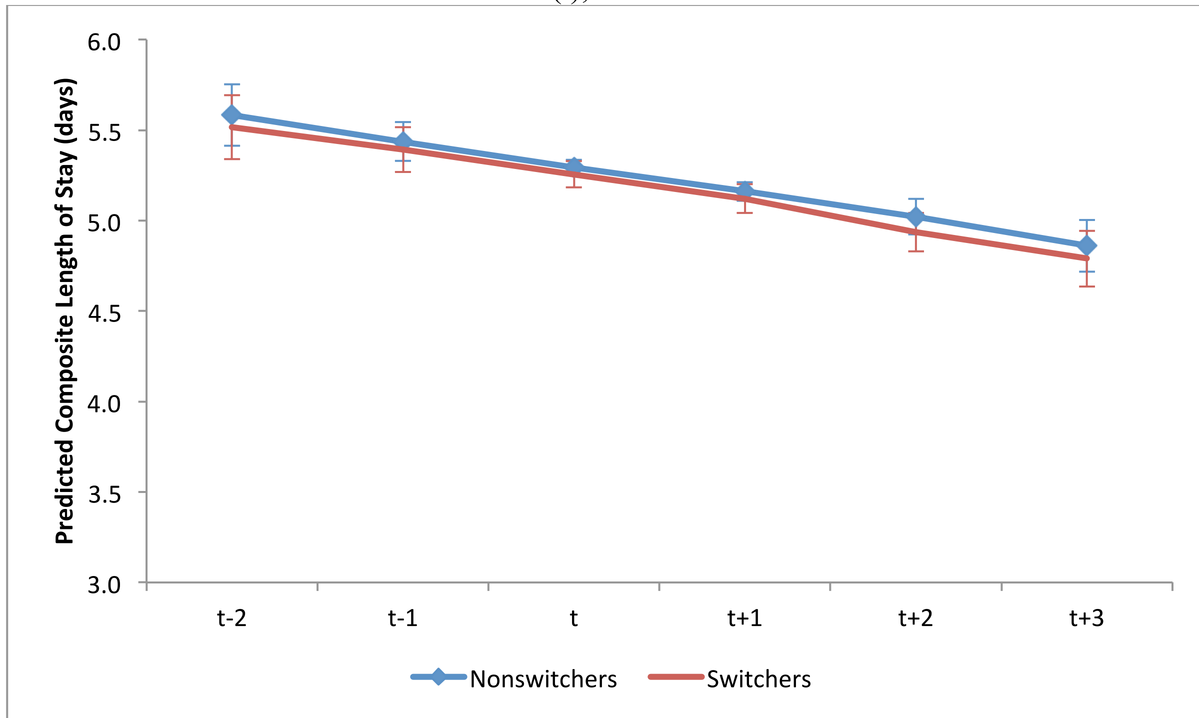


Figure 3.8. Predictive Margins of Composite Length of Stay between Switchers and Matched Non-switchers Relative to Year of Switch (t), with 95% Confidence Intervals



Patient Satisfaction

Figure 3.9. Unadjusted Percent of Patients Reporting High Satisfaction Score Between Switchers and Matched Non-switchers Relative to Year of Switch (t)

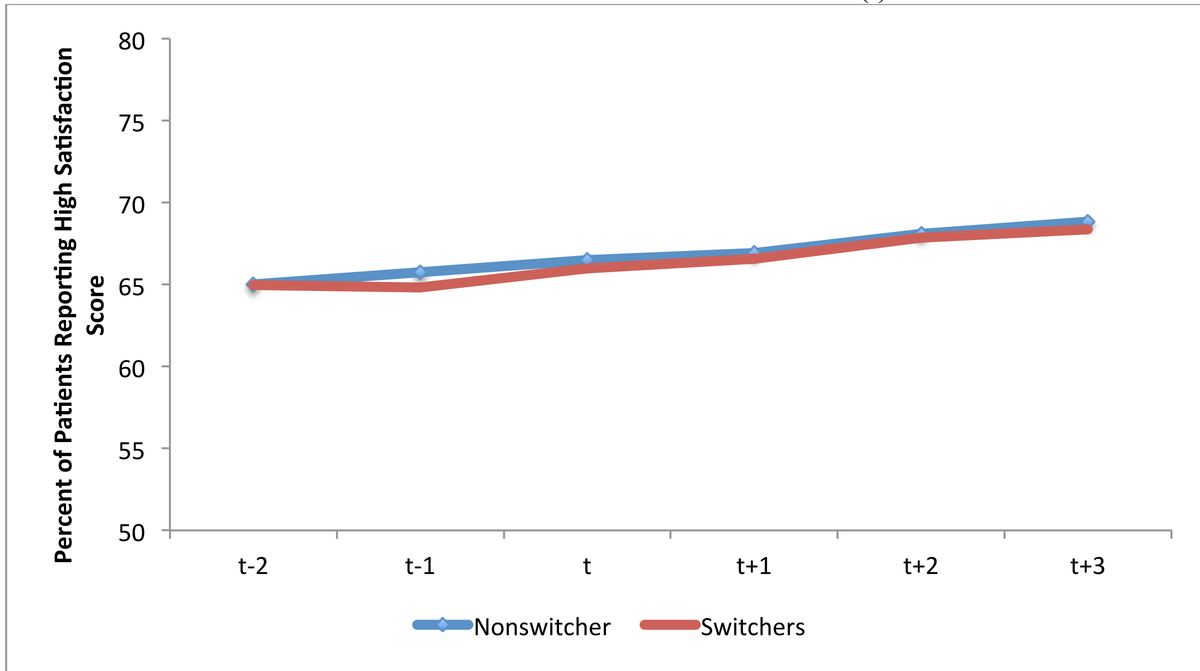
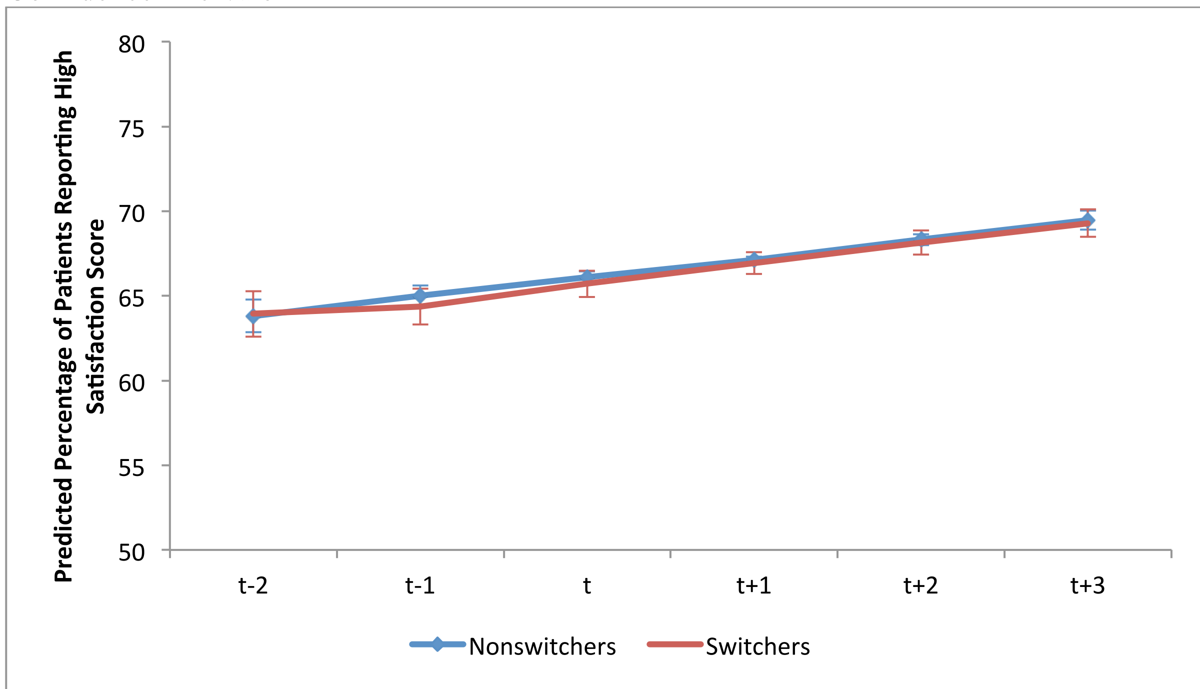


Figure 3.10. Predictive Margins of Percentage of Patients Reporting High Satisfaction Score between Switchers and Matched Non-switchers Relative to Year of Switch (t), with 95% Confidence Intervals



These figures above help to illustrate the trends over this study's observation period. To formally test whether or not switching into an employment affiliation was associated with improvements in quality, I conducted a series of difference-in-differences analyses. In **Table 3.6**, I summarize the predicted margins of each outcome of switcher hospitals two years prior to the year of the switch relative to non-switcher hospitals and then their performance three years after the year of the switch, as well as the effect of converting to an employment model on the outcomes of interest.

Across all measures (risk-adjusted mortality rates, readmissions, lengths of stay, and patient satisfaction), I found no evidence of differences between those hospitals that converted into an employment arrangement relative to those that had not over the observation period. For example, the composite mortality rate for switching hospitals remained flat from 12.6%, on average 2 years prior to switch to 12.6% up to 3 years after the switch. Among control hospitals, the change was 12.6% to 12.7% during the same time period (difference in differences, 0.08%, [95% CI: -0.31% to 0.16%]; p=0.52). Additionally, with respect to readmissions, the predicted composite 30-day readmission rate among switchers in the pre-period was 21.7% whereas it was 21.8% among non-switchers (difference = -0.10%, p=0.47). In the three years following conversion, the predicted composite readmission rate among switchers and non-switchers were both approximately 21.8% (difference = -0.07%, p=0.57). When I formally tested whether the difference-in-differences coefficient was statistically significant, I found that it was not: the effect of converting into employment status on composite readmissions was a slight increase of 0.02%, [95% CI: -0.26% to 0.30%]; p= 0.87) **(Table 3.6)**.

Table 3.6. Predicted Hospital Level Outcome for Switchers and Matched Non-Switchers in Same HRR Prior to and After Year of Switch, Adjusted Model

			Prior to Conversion	After Conversion	DD Coefficient (95% CI)	P-Value
			%	%	%	
Mortality Rate	**Composite**	Switcher	12.6	12.6	-0.08 (-0.31, 0.16)	0.52
		Non-switcher	12.6	12.7		
	AMI	Switcher	18.2	19.0	0.87 (-0.05, 1.81)	0.06
		Non-switcher	19.0	18.9		
	CHF	Switcher	11.5	11.5	0.13 (-0.29, 0.55)	0.55
		Non-switcher	11.3	11.4		
	PN	Switcher	11.3	11.4	-0.19 (-0.55, 0.17)	0.31
		Non-switcher	11.5	11.5		
Readmission Rate	**Composite**	Switcher	21.7	21.6	0.02 (-0.26, 0.30)	0.87
		Non-switcher	21.8	21.7		
	AMI	Switcher	21.2	21.3	0.32 (-0.65, 1.30)	0.51
		Non-switcher	21.4	21.1		
	CHF	Switcher	24.9	24.7	0.22 (-0.27, 0.72)	0.38
		Non-switcher	25.1	24.6		
	PN	Switcher	18.7	18.5	-0.06 (-0.46, 0.33)	0.77
		Non-switcher	18.7	18.5		
Length of Stay (days)	**Composite**	Switcher	5.1	5.2	-0.01 (-0.07, 0.04)	0.66
		Non-switcher	5.2	5.2		
	AMI	Switcher	4.6	4.6	0.01 (-0.07, 0.10)	0.78
		Non-switcher	4.6	4.6		
	CHF	Switcher	5.0	5.0	-0.01 (-0.09, 0.07)	0.80
		Non-switcher	5.0	5.0		
	PN	Switcher	5.5	5.5	-0.01 (-0.07, 0.06)	0.83
		Non-switcher	5.6	5.6		
Reporting High Patient Satisfaction	**HCAHPS**	Switcher	67.1	67.1	0.15 (-0.76, 1.06)	0.74
		Non-switcher	67.4	67.3		

I conducted a series of sensitivity analyses to evaluate the robustness of these aforementioned findings. This included estimating these outcomes using the random effects specification relative to fixed effects within the *xtreg* package, examining solely the unique hospitals that switched versus total switches, and the impact of switching into the ISM model only relative to not switching into this model (since this was the dominant category among this study's hospital employment grouping, see **Figure 3.1**). The results were not substantively different from these main findings noted above across all of these sensitivity analyses. Moreover, I estimated a series of linear regression models that excluded calendar year fixed effects, which is summarized in **Table 3.7**. Similarly, this analysis shows no overall differences between the treatment and control hospitals on hospital-level performance on these quality of care metrics.

Table 3.7. Predicted Hospital-Level Outcome for Switchers and Matched Non-Switchers in Same HRR Prior to and After Year of Switch, Adjusted Model Without Calendar Year*

			Prior to Conversion	After Conversion	DD Coefficient	P-Value
			%	%	%	
Mortality Rate	**Composite**	Switcher	12.8	12.4	-0.06	0.65
		Non-switcher	12.8	12.5		
Readmission Rate	**Composite**	Switcher	21.7	21.6	0.01	0.96
		Non-switcher	21.8	21.7		
Length of Stay (days)	**Composite**	Switcher	5.3	5.0	-0.02	0.51
		Non-switcher	5.4	5.1		
Reporting High Patient Satisfaction	**HCAHPS**	Switcher	63.9	68.1	0.13	0.79
		Non-switcher	64.2	68.3		

Note: These findings from my sensitivity analysis show the predicted values for the composite outcomes and patient satisfaction prior to and after conversion and the corresponding coefficient on the interaction term (*switcher*post*) for the fixed effects model that adjusts for all covariates, with the exception of calendar year. To clarify, these estimates come from a nearly exact model that produced the results as presented in Table 2 in the main text, however, it removes "calendar year" as a covariate and therefore does not include a fixed effect for each calendar year from which the data come from (2002-2012). These are qualitatively similar to the findings shown in **Table 3.6**.

3.4. DISCUSSION

Using a panel study design of all hospitals nationwide, I examined changes in U.S. hospital-reported affiliations with physicians over the past decade. I found that the proportion of hospitals employing physicians has increased steadily since 2003 and is now the most dominant arrangement that hospitals enter into with at least a subset of their admitting physicians. When examining hospital characteristics, I found that large, non-profit, teaching hospitals were more likely to have embraced this tightly-integrated relationship. While there has been mixed evidence suggesting the potential benefits or costs associated with this change, this study shows no impact on patient care across an array of metrics even up to three years out. Whether having hospitals employ physicians is indeed a key part of delivering higher quality, more efficient care, is unclear but these findings cast doubt on the notion that by itself, such a change is likely to have a meaningful impact.

This study expands upon previous studies indicating a fundamental realignment in the relationship between U.S. hospitals and their admitting physicians.[109,113,118,135,136] For hospitals, the investment in purchasing physician groups is likely motivated by changes in broader healthcare delivery and the need to secure a steady supply of patients.[111,112] For physicians, the complexity of independence may be becoming too difficult to manage, prompting many to consider employment as a more attractive, viable model to assure financial security.[111,114,123] And perhaps, irrespective of the motivation between each healthcare provider, this trend is only expected to grow in response to the delivery care reforms within the Affordable Care Act (ACA).[113,123]

This trend of increasing hospital employment of physicians may create both opportunities and challenges for patient care.[106,109,118] For example, by employing physicians, hospitals can more closely direct their activities and drive changes in care.[117,120] Moreover, greater integration between hospitals and physicians – such as through employment models – could improve outcomes by way of bolstering coordination efforts, increasing continuity of services, improving access to capital such as electronic health records, boosting physician satisfaction, and augmenting accountability for clinical performance (e.g., bonuses and withhold pools).[116,117,137] While some of these things are certainly taking place as hospitals increasingly employ physicians, this study suggests that – on the national level – this growth of vertical integration has not yet translated into better patient care among the hospital performance metrics examined in this study.[138]

An alternative motivator for why hospitals may be acquiring physicians is that it helps bolster their productivity, shore up referral bases, and gives them greater leverage in the marketplace when negotiating contracts with private payers.[111,123,139] Indeed, there is recent evidence – using a similar hospital-level approach – suggesting that these tightly integrated arrangements between physicians and hospitals are associated with higher prices and greater healthcare spending for private payers.[113,121] As such, if physicians and hospitals are using these employment models more for consolidation and financial advantage without a collaborative focus on improving quality, there would be little reason to believe that it would translate into better patient care.[140]

This study using recent national data (and focused on quality) adds to important work conducted in the 1990s using similar approaches to assess implications of vertical integration on both

healthcare spending and quality.[121,124,141] One prior study by Madison et al. (2004) examined the impact of such an affiliation on AMI patients in the 1990s and showed that integrated salary model (ISM) hospitals in particular (which are the dominant types of hospitals in this study's employment group) witnessed greater intensity of services relative to other hospital-physician affiliation models.[124] Another study, also from the 1990s, found modest declines in mortality in three states after physicians became integrated with hospital systems but failed to find benefits on other quality indicators they examined.[121] In addition to providing more recent evidence at the hospital level, this longitudinal analysis complements recent cross-sectional studies, at the physician level.[126,127,142] For example, using a novel national physician survey, Casalino et al. showed that physician-owned practices had lower rates of ambulatory care-sensitive admissions relative to hospital-owned groups.[142] Also, though it only relies upon one year of data, McWilliams et al. (2013) provided recent evidence of the importance of specialty mix when evaluating provider integration and its effects upon costs and quality; they found that larger, integrated physician groups with strong primary care orientations were associated with lower Medicare spending and better quality of care – in terms of readmission rates and performance on a range of HEDIS scores - relative to more independent physician groups.[143] These physician-group based studies complement this hospital-level analysis, which is the first-known study to examine the effects of the current era of hospital employment of physicians on quality of care.

Though I did not detect aggregate improvements in hospitals' quality performance as a result of these changes in physician-hospital affiliations nationwide, there is growing consensus that the status quo, where care is fragmented across the clinical spectrum, is no longer a viable option for the U.S. health care system.[134] This study, using contemporary national data, suggests that it will

take more than just changes in hospital-physician integration to fundamentally improve care delivery; and if physician employment is a key ingredient, it will need to be linked to others, such as hospital prioritization of quality as a key goal, in order to be successful.

3.5. CONCLUSION

This study adds to the growing body of evidence that there has been an important shift in the relationship between American hospitals and physicians. These findings suggest that for the first time in recent history, U.S. hospitals are more likely to become employers of physicians than any other kind of affiliation or relationship. This change will likely grow in the absence of antitrust legal or regulatory challenges to such a trend.[144] While some have theorized or advocated that hospital employment of physicians is likely to result in improvements to quality, this study provides no evidence that these quality gains have yet been experienced by hospitals recently entering into these employment relationships with their physicians. As hospital systems continue to acquire physician practices and employ physicians, health care leaders and policymakers should consider innovative ways to ensure that such arrangements translate into true clinical integration and be leveraged to improve quality of care.

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Appendix

Table A.1. List of Candidates, State, Political Party and Campaign Website, 2012

Year	Candidate	State	Party	Campaign Website
2012	Jack Markell	DE	Dem	http://www.markell.org/#
2012	Jeff Cragg	DE	Rep	http://www.cragg2012.com
2012	John Gregg	IN	Dem	http://www.greggforgovernor.com/
2012	Mike Pence	IN	Rep	http://www.mikepence.com/
2012	Jay Nixon	MO	Dem	http://jaynixon.com
2012	Dave Spence	MO	Rep	http://www.spenceforgovernor.com
2012	Steve Bullock	MT	Dem	http://stevebullock.com
2012	Rick Hill	MT	Rep	http://www.rickhillforgovernor.com
2012	Walter Dalton	NC	Dem	http://www.daltonfornc.com/
2012	Pat McCrory	NC	Rep	http://www.patmccrory.com
2012	Ryan Taylor	ND	Dem	http://taylorfornorthdakota.com
2012	Jack Dalrymple	ND	Rep	http://www.dalrympleforgovernor.com/
2012	Maggie Hassan	NH	Dem	http://www.maggiehassan.com
2012	Ovide Lamontagne	NH	Rep	http://www.ovide2012.com
2012	Peter Cooke	UT	Dem	http://www.cookeforgovernor.com
2012	Gary Herbert	UT	Rep	http://garyherbert.com
2012	Peter Shumlin	VT	Dem	http://www.shumlinforgovernor.com
2012	Randy Brock	VT	Rep	http://www.randybrock.com/
2012	Jay Inslee	WA	Dem	http://www.jayinslee.com/home
2012	Rob McKenna	WA	Rep	http://www.robmckenna.org
2012	Earl Ray Tomblin	WV	Dem	http://earlraytomblin.com/home
2012	Bill Maloney	WV	Rep	http://www.maloneyforwv.com

Table A.2. List of Candidates, State, Political Party and Campaign Website, 2014

Year	Candidate	State	Party	Campaign Website
2014	Parker Griffith	AL	Democrat	http://griffithforgovernor.com
2014	Robert Bentley	AL	Republican	http://bentleyforgovernor.com
2014	Sean Parnell	AK	Republican	http://www.parnell2014.com
2014	Bill Walker	AK	Independent	http://www.walkerforalaska.com
2014	Mike Ross	AR	Democrat	http://www.mikeross.com
2014	Asa Hutchinson	AR	Republican	http://www.asaforgovernor.com/home/
2014	Fred DuVal	AZ	Democrat	http://www.fred2014.com
2014	Doug Ducey	AZ	Republican	http://dougducey.com
2014	Jerry Brown	CA	Democrat	http://www.jerrybrown.org
2014	Neel Kashkari	CA	Republican	http://www.neelkashkari.com
2014	John Hickenlooper	CO	Democrat	http://www.hickenlooperforcolorado.com
2014	Bob Beauprez	CO	Republican	http://www.bobbeauprez.com/home
2014	Dan Malloy	CT	Democrat	http://www.danmalloy2014.com
2014	Tom Foley	CT	Republican	http://www.tomfoleyct.com
2014	Charlie Crist	FL	Democrat	http://www.charliecrist.com
2014	Rick Scott	FL	Republican	http://www.rickscottforflorida.com
2014	Jason Carter	GA	Democrat	https://carterforgovernor.com
2014	Nathan Deal	GA	Republican	http://dealforgovernor.com
2014	David Ige	HI	Democrat	http://www.davidige.org
2014	Duke Aiona	HI	Republican	http://www.dukeaiona.com
2014	Jack Hatch	IA	Democrat	http://www.jackhatch.com
2014	Terry Branstad	IA	Republican	http://branstadreynolds.com
2014	A.J. Balukoff	ID	Democrat	http://www.ajforidaho.com/
2014	Butch Otter	ID	Republican	http://www.otter4idaho.com/index.php
2014	Patt Quinn	IL	Democrat	https://www.quinnforillinois.com/00/
2014	Bruce Rauner	IL	Republican	http://brucerauner.com
2014	Paul Davis	KS	Democrat	http://davisforkansas.com
2014	Sam Brownback	KS	Republican	http://www.brownback.com/
2014	Martha Coakley	MA	Democrat	http://www.marthacoakley.com
2014	Charlie Baker	MA	Republican	https://www.charliebaker2014.com
2014	Anthony Brown	MD	Democrat	http://anthonybrown.com
2014	Larry Hogan	MD	Republican	http://www.hoganforgovernor.com
2014	Mike Michaud	ME	Democrat	http://www.michaud2014.com
2014	Paul LePage	ME	Republican	http://lepage2014.com
2014	Mark Schauer	MI	Democrat	http://markschauer.com
2014	Rick Synder	MI	Republican	http://www.rickformichigan.com
2014	Mark Dayton	MN	Democrat	http://markdayton.org
2014	Jeff Johnson	MN	Republican	http://johnsonforgovernor.org

Table A.2. (Continued)

Year	Candidate	State	Party	Campaign Website
2014	Chuck Hassebrook	NE	Democrat	http://www.chuckhassebrook.com/
2014	Pete Ricketts	NE	Republican	http://petericketts.com
2014	Maggie Hassan	NH	Democrat	http://www.maggiehassan.com
2014	Walt Havenstein	NH	Republican	http://waltfornh.com
2014	Gary King	NM	Democrat	http://www.garykingforgovernor.com
2014	Susana Martinez	NM	Republican	http://www.susanamartinez.com
2014	Bob Goodman	NV	Democrat	http://www.goodman4nevada.com
2014	Brian Sandoval	NV	Republican	http://briansandoval.com
2014	Andrew Cuomo	NY	Democrat	http://andrewcuomo.com
2014	Rob Astorino	NY	Republican	http://www.robastorino.com/index.php
2014	Ed Fitzgerald	OH	Democrat	http://www.edfitzgeraldforohio.com
2014	John Kasich	OH	Republican	https://www.kasichforohio.com
2014	Joe Dorman	OK	Democrat	http://joedorman.com
2014	Mary Fallin	OK	Republican	http://www.maryfallin.org
2014	John Kitzhaber	OR	Democrat	http://johnkitzhaber.com
2014	Dennis Richardson	OR	Republican	http://www.dennisrichardson.com/home
2014	Tom Wolf	PA	Democrat	http://www.wolfforpa.com
2014	Tom Corbett	PA	Republican	http://www.tomcorbettforgovernor.com
2014	Gina Raimondo	RI	Democrat	http://www.ginaraimondo.com
2014	Allan Fung	RI	Republican	http://www.fungforgovernor.com
2014	Susan Wismer	SD	Democrat	http://www.susanforsd.com
2014	Dennis Daugaard	SD	Republican	http://daugaardforgov.com
2014	Vincent Sheehan	SD	Democrat	http://vincentsheheen.com
2014	Nikki Haley	SC	Republican	http://nikkihaley.com
2014	Charlie Brown	TN	Democrat	n/a - no campaign website
2014	Bill Haslam	TN	Republican	http://www.billhaslam.com
2014	Wendy Davis	TX	Democrat	http://www.wendydavistexas.com
2014	Greg Abbott	TX	Republican	http://www.gregabbott.com
2014	Peter Shumlin	VT	Democrat	http://shumlinforgovernor.com
2014	Scott Milne	VT	Republican	http://www.scottmilne.org
2014	Mary Burke	WI	Democrat	http://burkeforwisconsin.com
2014	Scott Walker	WI	Republican	http://www.scottwalker.com
2014	Pete Gosar	WY	Democrat	http://www.gosarforgovernor.com
2014	Matt Mead	WY	Republican	http://meadforgovernor.com/

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