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Medicaid and the Policy Feedback Foundations for Universal Healthcare

By
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Public policies are products of politics, but they also *feed back* into the political system by shaping the actions and attitudes of members of the polity. To date, scholarly examinations of feedback processes have been mostly concerned with understanding the relationship between public policy and democracy; relatively little attention has been paid to connecting policy feedback to the practical questions that animate politics. This article examines policy feedback as it applies to efforts aimed at achieving universal health coverage in the United States—a widely held policy goal shared by a majority of American voters across partisan lines. I argue that in the contemporary political context, Medicaid—a pillar of the American healthcare system and the primary mechanism for insuring low-income and disabled citizens—can produce negative feedbacks that demobilize political action, destabilize advocacy groups, and deter coalition building. Together, these feedbacks undermine future possibilities for universal healthcare. After detailing these democratic dilemmas, I outline strategies for proactively addressing them.

Keywords: policy feedback; Medicaid; universal healthcare; negative feedback

Public policies can affect the trajectory of politics. This intuitive and astute observation forms the basis for a body of scholarship that systematically charts the political effects of public policy—a process known as *policy feedback* (Béland 2010; Campbell 2003, 2012; Lerman and Weaver 2014; Mettler 2005; Mettler and Soss 2004; Michener 2018; Patashnik and Zelizer 2013; Pierson 1993; Skocpol 1992; Soss 2000). Ideally, insights about policy feedback processes can be thoughtfully applied to illuminate pressing problems in the world. Yet even as scholarly

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knowledge of policy feedback grows in nuance and scope, it may not translate into relevant or useful information beyond the pages of academic books and journals. The translational prospects of policy feedback research depend on the extent to which scholars make their findings legible to wide audiences and relevant to real-world dilemmas (Hacker 2010). This article is one step in that direction. I leverage ideas from the policy feedback literature to think prospectively about how contemporary Medicaid politics is laying the groundwork for the future of health policy. This move from academic theorization and measurement to practical engagement with the world—though fraught in some ways—is a productive effort to confront "the problems and questions that govern our horizons as scientists of politics and policy in a nation whose tradition, language, and aspirations claim to be democratic" (Farr, Hacker, and Kazee 2006, 586).

In view of that goal, I argue that after the Affordable Care Act (ACA) became U.S. law, Medicaid politics prompted (at least) three negative feedback processes. If exacerbated and neglected, this negative feedback can hinder future efforts to expand access to healthcare. These matters have clear partisan implications. However, negative feedback is crucial for reasons that transcend strategic partisan calculations. Policy feedback that stymies political engagement, weakens political organizations, and hampers coalition building risks subverting (small-d) democratic policy outcomes. My arguments in this article hinge on the presupposition that, irrespective of any particular partisan implications, undermining participatory democracy is undesirable. In light of that assumption, I end the article with suggestions for strategies to counteract negative Medicaid feedback effects.

The Goal of Universal Healthcare: Why Medicaid Matters

According to a recent national survey by the Pew Research Center, six in ten Americans say that it is the federal government's responsibility to make sure all Americans have healthcare coverage (Kiley 2018). Perhaps even more strikingly, a 2018 Reuters-Ipsos survey found that 70 percent of Americans now support "Medicare for all," including 85 percent of Democrats and 52 percent of Republicans (Stein, Cornwell, and Tanfani 2018). Notwithstanding such bipartisan support, universal coverage policies are commonly perceived as politically infeasible (Brooks 2019; Faris 2017; Hiltzik 2016; Kelly and Alesci 2019; Robinson 2019; Siegel 2018; Stolberg and Pear 2019; Waldman 2018). Certainly, practical barriers like costs and administrative complexity make universal coverage a daunting goal. Nonetheless, many analysts agree that the most crucial dynamics of health policy are determined by politics (Hacker 2008, 2018; Grogan and Park 2017b; Mayer, Kenter, and Morris 2015; Rigby, Clark, and Pelika 2014; Rigby and Haselswerdt 2013; Roper 2007). Policy feedback scholars can thus contribute useful knowledge about the path toward universal healthcare by thinking critically about how existing policies create politics.

To that end, this article focuses on the policy feedback implications of Medicaid. Medicaid is a pillar of the American health care system. As the single

largest public health insurer in the United States, Medicaid provides health coverage for upwards of 72 million Americans (Centers for Medicaid & Medicare Services 2019). Given its size and scope, the future of any healthcare policy transformation likely pivots on the current-day status and effects of Medicaid policy. The political effects of Medicaid are especially germane. Recent research demonstrates that Medicaid affects political outcomes such as voting, participating in political groups, and policy attitudes (Clinton and Sances 2018; Haselswerdt 2017; Haselswerdt and Michener 2019; Hopkins and Parish 2018; Michener 2017, 2018). Medicaid policy shapes the political attitudes and actions of both individuals and organizations (Michener 2018). Given its role in producing the political conditions that structure the trajectory of health policy, Medicaid is central to assessing a route toward a robust universal healthcare system in the United States. Importantly, Medicaid's intergovernmental design, its development in the wake of the ACA, and its status in the larger healthcare system pose distinct policy feedback dilemmas. In the pages that follow, I outline these challenges and describe how the post-ACA context risks eroding the political foundation on which Medicaid rests and, thereby, makes universal healthcare a heavier political lift. I offer both offensive and defensive approaches to addressing this predicament. The problems I point to are difficult, and silver bullet solutions do not exist. Still, I sketch three strategies for diffusing negative policy feedback and generating positive feedback. I primarily emphasize states but also keep an eye toward national policy and politics.

Contemporary Healthcare Politics and Medicaid Policy Feedback

The politics of healthcare has grown even more explosive and polarized in the wake of the 2010 ACA. This is especially true with regard to Medicaid, a policy that reflects both the promise and peril of healthcare in the United States. In the last few years, we have seen vigorous efforts at the national and state levels to erode Medicaid. The 115th Congress attempted to advance a parade of unpopular "repeal and replace" policies. Though these policies had quite anodyne names such as the "American Health Care Act" and the "Better Care Reconciliation Act," they were each marked by a forceful drive toward large cuts to Medicaid. According to projections from the Congressional Budget Office, the repeal and replace policies would have led to tens of millions of people being uninsured, many as a result of reductions in Medicaid coverage via the imposition of per capita caps or block grants (Jost 2017). In response to threats to Medicaid funding, there was striking pushback from a wide range of stakeholders who stood to lose substantially if Medicaid were weakened (Cancryn 2017; Cancryn and Demko 2017; Michener 2018; Sarlin 2017; Stein 2017; Subberwal 2017). Such groups included program beneficiaries, doctors, hospitals, insurance companies, and organizations representing disabled and elderly Americans who count on Medicaid for their survival and long-term care.

The partisan political episodes around "repeal and replace" efforts made it pointedly clear that neither Medicaid's entrenchment nor its popularity will secure its political viability. Threats of cuts have loomed large even as Medicaid garners support from 74 percent of Americans, including 65 percent of Republicans.[1] Medicaid is an undoubtedly vital lifeline for tens of millions of Americans. Researchers have quantified the number of lives it saves and measured its effects on outcomes ranging from poverty to education to crime (Cohodes et al. 2016; Hu et al. 2016; Miller and Wherry 2018; Sommers and Oellerich 2013; Wen, Hockenberry, and Cummings 2017; Zewde and Wimer 2019). Seventy percent of Americans have had a direct personal connection to Medicaid.[2] Still, the program remains vulnerable. Given that the fate of universal healthcare is linked to the fate of Medicaid, the interplay between Medicaid policy and politics—and the resulting feedback—warrants close attention.

To date, the leading story of policy feedback and Medicaid in the era of the ACA is positive. Several studies find that the ACA's Medicaid expansion was a boon for voter turnout (Haselswerdt 2017; Clinton and Sances 2018). This research is valuable, but it focuses solely on the short-term participatory effects of the recent Medicaid expansion. A broader look at Medicaid policy feedback reveals a more complex set of political forces. For example, federalism gives states and localities marked influence over the contours of Medicaid. This makes for a "many-headed" policy that takes very different forms in different places and has direct implications for politics (Michener 2018; Sanger-Katz 2015; Sparer 1996; Thompson 2012). Federalism can fragment the politics of Medicaid, splinter policy coalitions and interest groups, raise barriers to political coordination across locales, impede democratic accountability, and differentially demobilize policy beneficiaries as well as those who live in communities alongside them (Michener 2017, 2018; Haselswerdt and Michener 2019). All in all, increased voting in the immediate aftermath of Medicaid expansion is but one potential feedback effect in this bigger picture. Others include (1) effects on the advocates and activists attempting to organize and mobilize in the realm of healthcare; (2) effects on those Americans insured via state marketplaces who may become disenchanted with their coverage relative to the perceived benefits of Medicaid; and (3) effects of Section 1115 waivers—institutional mechanisms that provide states with leeway to depart from federal statute and test new Medicaid policies—and other administrative interventions into Medicaid. Unlike Medicaid expansion, these feedbacks are negative, potentially demobilizing Medicaid beneficiaries and stigmatizing the program more broadly. Below, I consider the implications of each of these three policy feedback dilemmas in more detail.

Feedback Dilemma #1: Demobilizing Policy Advocates and Activists

The first source of negative policy feedback in the current healthcare landscape has to do with how the ACA shapes the political context in which policy advocates and activists operate.[3]

The ACA has profoundly polarized the politics of healthcare, creating marked incentives for a wide variety of stakeholders to become more intensely involved with health policy (Béland, Rocco, and Waddan 2015; Hertel-Fernandez, Skocpol, and Lynch 2016; Gray, Lowery, and Benz 2013; Rocco and Haeder 2018). On the ground, this makes for a more fraught policy process. In particular, this shifts the contours of health policy for advocates and interest groups seeking to move the healthcare system toward an expansive, equitable, and universal structure. As battle lines have been drawn over "Obamacare," organizations that might have otherwise been focused on making forward progress in terms of the quality, scope, and equity of healthcare are instead engaged in a constant series of political skirmishes largely oriented around defending the ACA.

In the last several years, during the process of writing a book about Medicaid and since the publication of that book, I have engaged extensively with the leaders of health policy organizations across the country. I have given presentations at their annual meetings, consulted them on the politics of Medicaid, helped them to craft surveys, and had in-depth conversations with them about the work that they do. Along the way, I have observed that the politics of the ACA has twofold consequences for political organizations focused on improving healthcare access and equity. On one hand, fighting for the ACA can energize these organizations, provoking action and coordination. On the other hand—and especially over the long run, as ACA-related political battles rage on—the politics of the ACA can destabilize, distract, and dishearten policy advocates. For example, in a recent phone conversation, the leader of a healthcare advocacy organization in an embattled southern state described policy advocates in her state as being "discouraged" by the fight against Medicaid work requirements. After a long effort to expand Medicaid, the prospect of yet another barrier to care was dispiriting. In 2010, when the ACA was passed, many health policy advocates celebrated the prospect of expanding Medicaid. Since then, they have been compelled to fight harder than ever simply to defend the status quo against retrenchment. Although such political actors continue to push back as each new hurdle is erected, doing so absorbs energy that might otherwise be useful for mobilizing more broadly and deeply, thinking beyond the most immediate political challenges and organizing affirmatively—not just against regressive change but for positive change. Many of the phone calls, meetings, and consultations I have been a part of for the last few years have been focused on how to protect Medicaid, while comparably few have been geared toward farsighted envisioning of ways that Medicaid can play a part in a larger move toward universal care. While taking a defensive posture at this political moment makes sense for Medicaid advocates, doing so constrains the capacity building and imagination necessary to move toward a different future.

Relatedly, the language, tactics, and action that political organizations take have been altered by the hyperpolarized post-ACA politics (especially in conservative states). This can generate organizational fissures and divisions. For example, I have seen policy advocates divided over whether to accept and support Medicaid expansion accompanied by work requirements or whether to reject expansion when such strings are attached. More pragmatic advocates view

expansion as a fast track to vital gains for tens of thousands of people and are, thus, willing to compromise. Less sanguine advocates worry that opening the door to conditional coverage lays the foundation for a weakened program and imperils the health of the people who would be left behind under work-oriented Medicaid regimes. Organizations that would otherwise work together can thus find themselves at odds over this disagreement (and others). As a result, cooperation and collaboration among policy coalitions can be elusive.

Another adverse upshot of the tough policy environment that many state healthcare advocacy organizations currently face concerns changes in the regulatory and bureaucratic environment of state and local health policy. The ACA has placed a spotlight on Medicaid. While this is a good development in some ways, it also has disadvantages. Particularly in politically "red" or "purple" states, as government officials contemplate implementing Medicaid expansion or as they actually begin to expand, they also often search for ways to "reform" Medicaid to make it more efficient, less costly, and more politically palatable. The search for routes to reform opens up possibilities that were otherwise not included in the repertoire of policy options (Weaver 2010; Jacobs and Weaver 2015), some of which are subtle and bureaucratic but nonetheless important. Most people are unaware of such developments, but advocacy organizations are tasked with responding to them on the frontlines—and they expend scarce resources and time to do so. For instance, in Kentucky, amid high-profile contention over Medicaid expansion, Medicaid bureaucrats decided to more strictly interpret a rule requiring Medicaid beneficiaries to have up-to-date addresses. They required that Medicaid enrollees verify their addresses and flagged beneficiaries whose mail was returned to sender. They then disenrolled people for violating this technicality.[4] In the wake of disenrollment related to address mismatches, advocacy organizations had to reroute energies toward tackling this matter. In this way, resistance to Medicaid expansion (even in states that decide to expand) generates barriers to access for Medicaid beneficiaries and levies a tax on health advocacy organizations that must most directly confront such barriers.

In sum, the policy issues and polarization that dominate ACA-era health politics can lead to splintering, narrowing, cautiousness, and resource depletion among health policy organizations seeking to expand access and improve equity.

Feedback Dilemma #2: Failed Insurance Marketplaces Breed Resentment

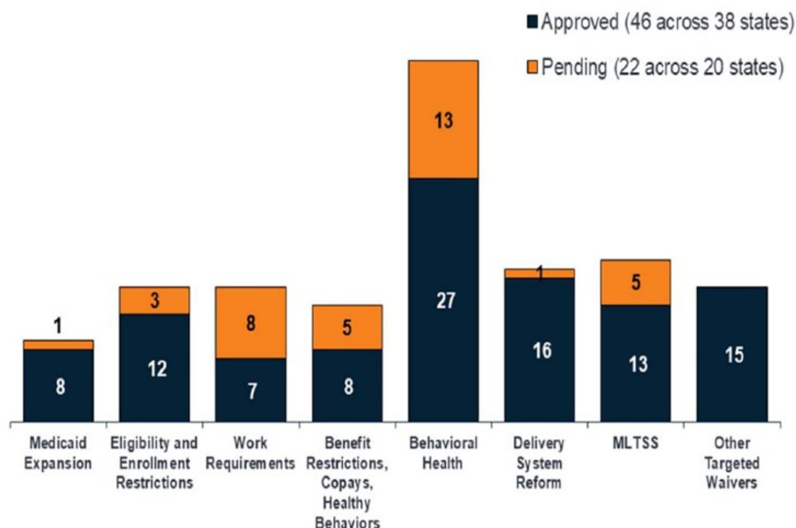
The second negative policy feedback I address concerns the failures (real and perceived) of the ACA. Though Medicaid is the main emphasis here, it does not exist in isolation from the other parts of the ACA. Instead, the other major pieces of the ACA work in tandem with Medicaid expansion and sometimes at cross-purposes with it. Take state insurance marketplaces, for example. While Medicaid expansion has emerged as the centerpiece of the ACA, state

marketplaces have struggled. The insurance marketplaces have been “buffeted in many states by high premium increases, sicker-than-expected risk pools, and insurer withdrawals” (Oberlander 2017). Crucially for policy feedback, the class politics of this problem pits would-be allies in the healthcare realm against one another. The marketplaces were designed as an option for lower-middle- and middle-income Americans. Many of those intended constituents now face disappointment over the skyrocketing prices of premiums and the instability of the marketplaces (Semanskee, Claxon, and Levitt 2017). In 2017, 69 percent of Americans surveyed in a Kaiser Health Tracking Poll said that it was “extremely” or “very” important to pass legislation to stabilize ACA insurance markets.[5] The observable discontent of marketplace consumers is too easily juxtaposed with the salient expansion of Medicaid and the perception that it is a better option than others. In 2018, 52 percent of Americans (including 50 percent of Republicans) reported believing that Medicaid was “working well for most low-income people covered by the program.”[6] In the eyes of “working”- or “middle”-class Americans, their primary option for receiving care has fallen short, while the benefits that flow to Americans living in poverty seem high quality and ever expanding (of course, reality is much more complicated than that). This arrangement risks cultivating a political environment ripe for vilifying Medicaid in the eyes of better-resourced Americans who are struggling to pay for health insurance and facing frustration over the limits of state marketplaces. The feedback challenge at stake here has to do with the politics of intergroup class dynamics given the variable success of different parts of the ACA, some of which map onto insurance coverage for particular socioeconomic groups. Overlaying these class dynamics are equally important racial dynamics (Michener 2019). The perception that Medicaid beneficiaries (read: poor black people) are getting stuff while hardworking Americans (read: “working-class” white people) lose out, however misguided, can produce a more toxic racialized health politics than we already have and prevent cross-class, cross-race mobilizing that could secure universal healthcare in the long run (Grogan and Park 2017b; Tesler 2012).

Feedback Dilemma #3: Section 1115 Waivers Demobilize and Stigmatize

The third negative feedback possibility I consider involves the broadening of states’ policy options through Section 1115 waivers. Such waivers have long existed, but ACA politics has given states an incentive to push the bounds in terms of the design of waivers, and the presidential administration of Donald J. Trump has encouraged such stretching. The most salient waivers impose work requirements on Medicaid beneficiaries. Even beyond that, waivers are wide ranging. Pending and approved waivers include lockout penalties that prevent beneficiaries from accessing care for some prescribed period of time after noncompliance with a given eligibility condition; drug screening, allowing states to

FIGURE 1
Landscape of Approved and Pending Section 1115 Medicaid Demonstration Waivers



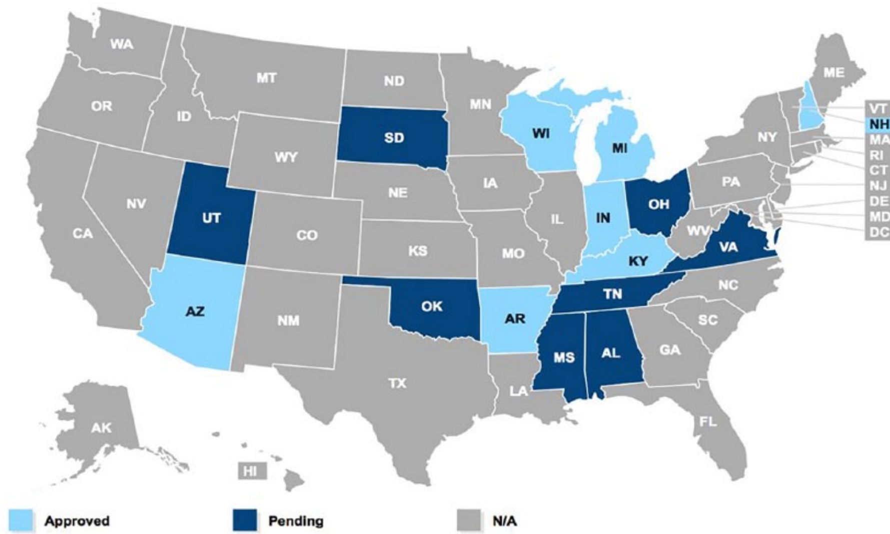
SOURCE: Kaiser Family Foundation Medicaid Waiver Tracker (as of January 23, 2019).
NOTE: MLTSS = Medicaid Managed Long Term Services and Supports.

implement screening for substance abuse disorders among beneficiaries; "reasonable promptness" provisions that allow states to delay the start of coverage until after the first premium is paid; the elimination of retroactive coverage so that new beneficiaries are not covered for the limited period immediately before formal enrollment; the elimination of transitional medical assistance so that beneficiaries who find work (or better work) lose benefits due to increased income without a transition period; elimination of presumptive eligibility so that hospitals cannot proceed with providing care on the presumption that certain patients are eligible; and more (see Figures 1–3).

The overarching theme of these waivers is that they limit coverage, introduce administrative burdens, and increase the likelihood that people will lose benefits (Herd and Moynihan 2019). Such waivers can produce negative feedback in numerous ways. Most proximately, by politically demobilizing Medicaid beneficiaries. Political demobilization can happen if waivers lead to substantial disenrollment from Medicaid because disenrollment can lead to decreased voting (Haselswerdt and Michener 2019). More generally, disenrollment limits the reach and effectiveness of Medicaid during a time when building political capital for more expansive healthcare requires extending the reach of health programs and improving their effectiveness.

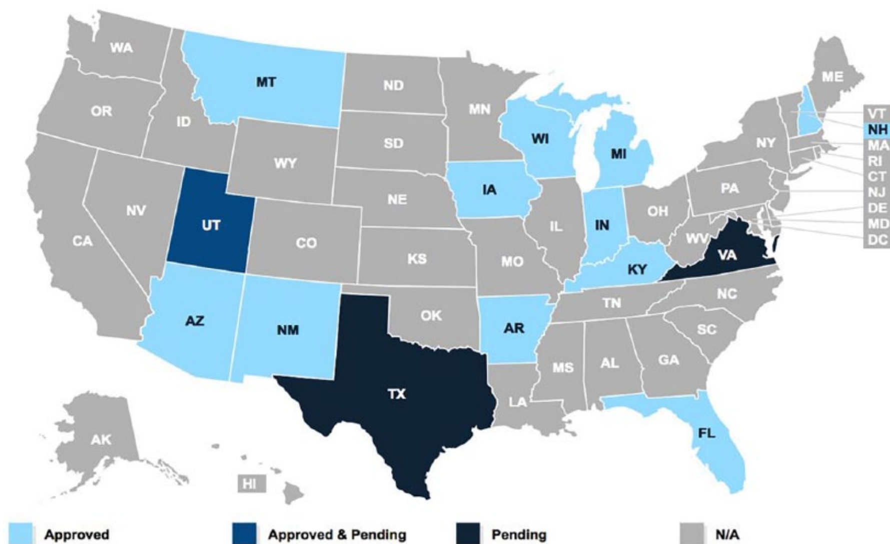
Political demobilization as a result of waivers can also happen in response to the negative experiences they produce for Medicaid beneficiaries (Michener

FIGURE 2
Section 1115 Medicaid Waivers: Work Requirements



SOURCE: Kaiser Family Foundation Medicaid Waiver Tracker (as of January 23, 2019).

FIGURE 3
Section 1115 Medicaid Waivers: Eligibility and Enrollment Restrictions



SOURCE: Kaiser Family Foundation Medicaid Waiver Tracker (as of January 23, 2019).

2018). Especially perniciously, the administrative burden associated with waivers will target the “most advantaged” among Medicaid beneficiaries (i.e., people in the expansion population who are slightly less poor, less unhealthy, and more connected to the labor market). Waivers therefore risk alienating the beneficiaries who are closest to the “working” and middle classes and who could otherwise build a stronger bridge for cross-class coalitions. Looking beyond beneficiaries, waivers can fuel the stigmatization of Medicaid. They may signal to the broader public that Medicaid beneficiaries must be policed, controlled, and watched (Schneider and Ingram 1993; Soss and Schram 2007). Medicaid is a program that is closely connected to many Americans, and at present, it is not intensely stigmatized among the general public (Grogan and Park 2017a). Waiver policies risk reversing that course by codifying and reinforcing stereotypes about the kinds of people who rely on Medicaid (nonworkers) and the necessity of social control for subsets of the Medicaid population (nonworking able-bodied adults).

Countering Negative Feedbacks and Generating Positive Feedbacks

With these policy feedback dilemmas in mind, I propose three strategies for counteracting the democratic erosion that they threaten. Admittedly, these strategies come with their own challenges, and their feasibility will vary depending on state contexts and federal political developments. My objective is to highlight courses of action that have the potential to cultivate a more democratic polity and an equitable healthcare system.

Build political momentum for health care at the state level

I recently talked to a state health policy advocate who told me that “everyone wants national solutions but we forget that every good thing that has ever happened at the national level started in the states.” If the “good thing” one seeks nationally is political power to create an equitable universal healthcare system, then advancing toward that goal begins at the state level. Building political momentum in the states is an offensive strategy for eventual national change. Of course, there are many rounds of politics required to propel the progression from state to national, and I cannot lay all of them out here. Nonetheless, I recommend two distinct kinds of efforts: (1) broad coalition building and (2) visionary agenda setting.

As intimated above, the ACA has intensified the degree to which state-level organizations are mired in a complex policy environment that continually distracts, destabilizes, and discourages them from working optimally. Furthermore, the uneven success of the ACA risks splintering the interests of healthcare consumers along lines of class and race. Together, these negative feedback processes can dampen coalitional possibilities by straining the organizations that might

work to forge coalitions and dividing those with the most at stake. To generate positive policy feedbacks, health advocacy organizations, healthcare providers, and other relevant groups must coalesce. Particularly important is that such groups organize with attentiveness to bridging class, race, and issue-based subgroups. Advocacy and other organizations must create opportunities for the most sympathetic and publicly supported health consumers (e.g., people with preexisting conditions, people with disabilities) to make common cause with the least-supported health consumers (e.g., nonworking able-bodied adults). The hardest task of coalition building will be to cut through the many issue-based, ideological, and partisan silos that characterize the health policy arena to systematically enlarge the size and power of healthcare constituencies.

In practice, this will require organizations across the spectrum of health policy interests to build political capacity. That process will be different in each state. Some states have already undertaken campaigns that required building coalitions (e.g., states that have mobilized to get Medicaid expansion passed via ballot initiative). In those places, organizations must continue to see beyond short-term campaigns, holding together coalitions and expanding them even during times where health policy issues seem more dormant than previously. Lawmakers will have to craft policies that cut across healthcare consumer subgroups and are relevant to as many organizations and individuals as possible. Policy-makers and organizations can work together to identify synergies, as organizations can alert policy-makers to opportunities to develop and push legislation that has the most expansive possibilities for organizing. This is possible even in politically conservative states where such policy may be very difficult to pass. Whether or not policies are passed, the policy process itself can create opportunities for state coalitions to organize together, to test the political waters, and to see what is feasible given developing configurations of coalitions. Any policy passed is a boon for such coalitions; and with careful expectation management, even policies with widespread coalitional support that do not pass can be made into a political liability for recalcitrant politicians who refuse to respond to their constituents.

Ultimately, only better-resourced, higher-capacity organizations can afford to look beyond the immediate political context to build toward more expansive possibilities. Providing state policy advocates with financial and political resources to enable them to build organizing capacity is, therefore, crucial. At the same time, having a broader vision does not mean overlooking the nuts and bolts of what many state advocacy organizations do well. A complementary way to build capacity is to achieve and highlight very local gains (like changes in burdensome administrative practices). When organizations engage in smaller political battles for the purposes of fighting against immediate barriers to care, it is more than small potatoes. Their core constituencies should know about it and be engaged for "small" winnable battles that reinforce infrastructure and morale as building blocks for larger efforts. Integrating both macro (going after state-level policy change) and micro (going after local or particularistic bureaucratic changes) policy approaches into a larger plan for coalition building across wide swaths of health consumer groups is a path toward generating positive feedback effects.

Policy-makers and bureaucrats are potential partners in the organizational capacity building efforts described here. They have opportunities to interact with a wide range of organizations, can productively connect such organizations to one another, can devise legislative or bureaucratic channels to distribute resources to such organizations, and can brainstorm about how to structure policy in such a way as to promote the broadest coalitions possible. Local media are also potentially key actors in this regard because they can make the work of local organizations salient, inform the public about otherwise unnoticed fights that such organizations continually wage, and amplify the messages and voices of organizations that do not have the capacity to manage public relations or shape public discourse.

Set an expansive agenda

The core idea here is simple: states that have the power to do so should take big, bold steps toward expanding healthcare on a state level. This logic applies to localities (indeed, the mayor of New York City recently committed to a plan for providing comprehensive health care for all city residents including undocumented immigrants). Bold policy progress will only be possible in a few places, but it is nonetheless a key step in leveraging states and localities as the "laboratories of democracy" that they are so often purported to be. Major state and local policy advances can demonstrate that policy approaches now perceived as infeasible are indeed possible. Of course, great care is warranted here. If states and localities implement policies that are bold failures, they risk stifling the effort to demonstrate the feasibility of these policies on the national stage. Moreover, if states advance policies that represent some progress, but those policies retain many of the more profound limitations of the current system (e.g., limited attentiveness to long-term care, insufficient mechanisms to control costs and pricing, marked class or race inequities), then even the "success" of such policies can be limiting by perpetuating the existing problems in the system and setting a ceiling for future policy advances. In short, one cannot assume that any bold action on the state and local levels will suffice. To forfend against making things worse, states with the political majorities necessary to take bold action must think beyond the state level and look beyond the moment. Those states should explicitly confer with other states as well as with national organizations to reasonably evaluate the long-term implications of their policy choices. This means strategizing about how any policy under consideration fits into a broader national path toward universal coverage. Applying this lens—a multilevel policy feedback perspective—will be difficult, but it can change the calculus for more forward-thinking states looking to take the lead. If a critical mass of states and localities make intrepid progress that is also strategically designed as part of a longer-term national focus, there will be more evidence useful for designing and justifying bold policies at the national level. Moreover, diffusion effects could create cross-state patterns that generate positive feedback at both the state and national levels.

Create policy and administrative protections to reinforce Medicaid

This set of recommendations focuses on defensive strategies that limit negative feedbacks associated with the ACA. On a national level, the best (medium term) policy protection against fueling politically damaging antipathy toward Medicaid is to strengthen the other aspects of the ACA by stabilizing the insurance marketplaces and securing protections for preexisting conditions. As noted earlier, Medicaid is not at its strongest if the policies targeting the middle-class flounder. Such an arrangement can sow seeds of cross-class divisions that risk hindering broad-based coalition building at the state and national levels. National policy-makers should pursue policies that offset the failures of the marketplaces. Federal policies with these aims are already on the table, but a feedback-oriented perspective sheds a different light on this sort of defensive legislation in at least two ways. First, though protecting the ACA may seem like a narrow endeavor given more stirring calls for "Medicare for All," the two efforts can be part and parcel of a policy feedback perspective. Constituents who perceive the ACA as a disaster because of negative experiences with the health insurance marketplaces may be even less trusting of government and thus even less amenable to calls for universal coverage. For similar reasons, people may also be more hostile toward Medicaid and its beneficiaries. Preventing such negative feedbacks in the present means short-term "fixes" like marketplace stabilization. Such interventions do not foreclose more expansive future possibilities. A second important insight that follows from the vantage point of feedback effects is that efforts to shore up the ACA must be public, identifiable, and comprehensible to the public. The minutiae of the ACA, the exchanges, and the rules around preexisting conditions can easily distance the average constituent and hide the role of the government (Mettler 2011). Along with passing legislation focused on stabilization, a major goal of national policy-makers should be to make the concrete implications of such legislation very salient.

On the state level, steps to protect Medicaid via bureaucratic administration are important. Such efforts include closely monitoring and evaluating the administrative implementation of Medicaid expansion to constrain the political side effects of regressive waivers. Some political organizations are already evaluating the effects of waivers or planning to do so. Supporting such efforts financially and through bureaucratic mechanisms for policy evaluation is a first step, and doing so is justifiable across ideological contexts. Understanding how waivers are unfolding is crucial for assessing their effects. A secondary and politically relevant upshot of formally assessing the effects of waivers is that measurement and assessment are crucial for making a legal case against waivers when there is evidence that they are harmful.

Finally, to protect and reinforce Medicaid on both the state and national levels, elected officials, bureaucrats, media, academics, and anyone in a position to shape policy discourse should think carefully about how to talk about Medicaid and its beneficiaries, what other programs to connect it with, which populations to highlight, and which aspects of Medicaid policy they emphasize. This may seem small, but policy discourse and political communication matter, especially for building

long-term change (Gillion 2016; Levine 2015; Scrase and Ockwell 2010). Emphasizing the wide reach of Medicaid is key given that people with closer connections to the policy are more supportive of it (Grogan and Park 2017a). Linking the fate of Medicaid to the fate of the health system more broadly (and specifically the fate of interests relevant to middle-class Americans) is also crucial. At the same time, caution is in order on two counts. First, downplaying Medicaid's role in supporting low-income Americans and depicting it as a "middle-class" program is not a sustainable strategy. If the goal is to build cross-class coalitions, then middle-income Americans need to value a program that disproportionately benefits people living in poverty, not eschew it. This is why rhetoric and framing that links the fate of low-income Medicaid beneficiaries, middle-income long-term care and disabled beneficiaries, and other (non-Medicaid) healthcare consumers (like people with preexisting conditions) is optimal. Second—and most concrete for policy purposes—practices around talking about Medicaid programs are easy to overlook, but important. The preferable course of action is to advocate for program names, descriptions, and public-facing language (on websites, in pamphlets, etc.) that center the value and sources of Medicaid benefits and decenter technocratic language about eligibility and costs. When Medicaid programs have names that obscure the resources that the program offers and highlight its burdens (e.g., Arizona's Medicaid agency is called the Arizona Healthcare Cost Containment System) and when public officials and public-facing materials emphasize costs, eligibility limitations, and scarcity, there may be negative long-term consequences for how the public views the program. Even Medicaid advocates tend to fall into these rhetorical patterns, so there is a need for the widescale adoption of language and framing that is more sensitized to the feedback processes that might be set in motion by political discourse.

Extend the reach and function of Medicaid

This final set of recommendations is based on a core observation: positive feedback effects will proliferate as Medicaid works better for more people with more visibility that is explicitly linked to policy decisions and politics (Campbell 2003; Mettler 2005, 2011). The ACA expansion has been one part of this, but strengthening Medicaid politically and building from that strength to achieve further gains requires continuing to expand the reach and role of Medicaid. I suggest at least three ways of doing this.

First, make existing Medicaid coverage as accessible to as many people as possible through increased funding (at the state and national levels) for outreach and enrollment via intermediaries like healthcare navigators, social workers, and community health workers. My interviews with Medicaid beneficiaries and community health workers alike reveal that these actors can play an important role in making experiences with Medicaid more positive, by lightening administrative burden and preventing disenrollment. Such positive experiences make it more likely for Medicaid to exert positive feedback effects in ways that support future transformative change. Between 2017 and 2018, federal funding for health navigator programs that support enrollment and outreach was cut by 84 percent (Keith

2018). To the extent that national policy-makers can reverse this direction, positive feedbacks may be more likely. States can also devote more funding to such efforts.

Second, pursue an expanded public health model of state Medicaid policy-making and administration that focuses on the social determinants of health. Doing so can extend the reach and role of Medicaid in people's lives, further entrenching it, creating more positive feedback effects, and providing evidence that more health care support is both morally and fiscally responsible. Some states are already leading the way in this regard by using Medicaid funds to cover costs such as housing, transportation, medical-legal partnerships, and more. States should look for creative ways to use existing Medicaid resources to these ends. Medicaid waiver demonstrations are already used for the purposes of supporting housing, legal services, and other crucial resources to Medicaid beneficiaries. As of this writing, three states (Delaware, Hawaii, and Maryland) provide supportive housing services as part of Section 1115 waivers, and at least six states use Section 1915(c) waivers to deliver housing-related services such as supports to transition into community-based living, home modifications, and one-time moving expenses (Jopson and Regan 2016; Musumeci 2017). Some of these waivers are in politically conservative states. For example, the Louisiana Department of Health operates a permanent supportive housing program financed through state funding streams that include Medicaid. Other Section 1915(c) waivers help the state to provide pretenancy, tenancy crisis, and tenancy-maintenance services. These and other policies help to support Medicaid beneficiaries in more and varied ways, stabilizing them and making positive policy feedback more viable among them. States should not lose sight of the benefits of waivers focused on leveraging Medicaid to address the social determinants of health that impede the economic and political lives of Medicaid beneficiaries.

Third, state and federal policy-makers should increase support for institutions that inform and empower healthcare consumers. Such institutions already exist in some states (e.g., the office of the healthcare advocate in Connecticut, the office of the patient advocate in California). Expanding support for and creating more nonpartisan state institutions that can help to inform and engage health constituencies is a potentially valuable step toward engendering positive policy feedbacks. Such institutions could assist in ensuring that Medicaid beneficiaries and other healthcare consumers have the best possible experiences with government programs, that they are empowered to defend their social rights and navigate otherwise alienating bureaucratic frustrations. The infrastructure for these institutions already exists in some places, but it can be extended, solidified, and made more salient. In other places, no such institutions exist, but they can be created via collaborative efforts (for example, Vermont's health care advocate project is operated through Vermont legal aid) and with state and national support. State health consumer advocacy institutions are achievable but not minor; they could play a role in creating an infrastructure of support that promotes the democratic inclusion of healthcare constituencies of all kinds.

Conclusion

The observations proffered here apply research on policy feedback to contemporary political dilemmas. The suggestions that followed illuminate potential mechanisms for generating positive policy feedback or neutralizing negative feedback. State capacity building catalyzes the political groundwork useful for mobilizing political resources in support of desired change. Bold state action sets nationally relevant precedent. Policy and administrative backstops attend to the weaknesses of the ACA, increasing chances for fruitful cross-class mobilization (or at the very least, stemming the tide undermining such possibilities). Extending the reach and functions of Medicaid by making existing programs more accessible, being more attentive to policy concerning the social determinants of health, and further developing consumer advocacy institutions are steps that make Medicaid more politically inclusive. Ultimately, I do not highlight these strategies for partisan purposes. I do so in view of an unoriginal yet compelling principle: "Political science has a unique ability, and even perhaps a special obligation, to engage with issues of democratic choice that fundamentally affect the life circumstances of citizens" (Farr, Hacker, and Kazee 2006, 579).

Notes

1. These numbers are from the Kaiser Family Foundation Health Tracking Poll (February 2018). The polling data are available online from https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/.

2. Ibid.

3. It is important to note that state political environments vary significantly. Key sources of variation to consider include (1) whether states have adopted Medicaid expansion; (2) the density and power of health interest groups, which varies significantly across states (Gray, Lowery, and Benz 2013); and (3) healthcare expenditures per capita, which range from very high (D.C. spends $11,944) to much lower (Utah spends $5,982).

4. Here is an example of a letter describing the new policy that was sent to Kentucky health care providers: https://www.caresource.com/documents/member-address-mismatch-disenrollment/. Here is another example describing some of the details and detailing the actions that healthcare providers must take to prevent disenrollment: http://passporthealthplan.com/wp-content/uploads/2015/08/08-18-PROV51713-Member-Disenrollment.pdf.

5. Kaiser Family Foundation Health Tracking Poll (September 2017): https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-september-2017-whats-next-for-health-care/?utm_campaign=KFF-2017-September-Tracking-Poll&utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz–pbtZgGfclYLHnR762ynztwF9i1j2qZa1febywFuMGu5TVPXajfPgbVdvT-FrHpNh18NwmhIZdnoSKCkhKFRM-yjHhoBw.

6. Kaiser Family Foundation Health Tracking Poll (February 2018). The polling data are available online from https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/.

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