



Milbank Memorial Fund

REPORT

**Views from the Heartland:
Prospects for Bipartisanship in
Health Reform**

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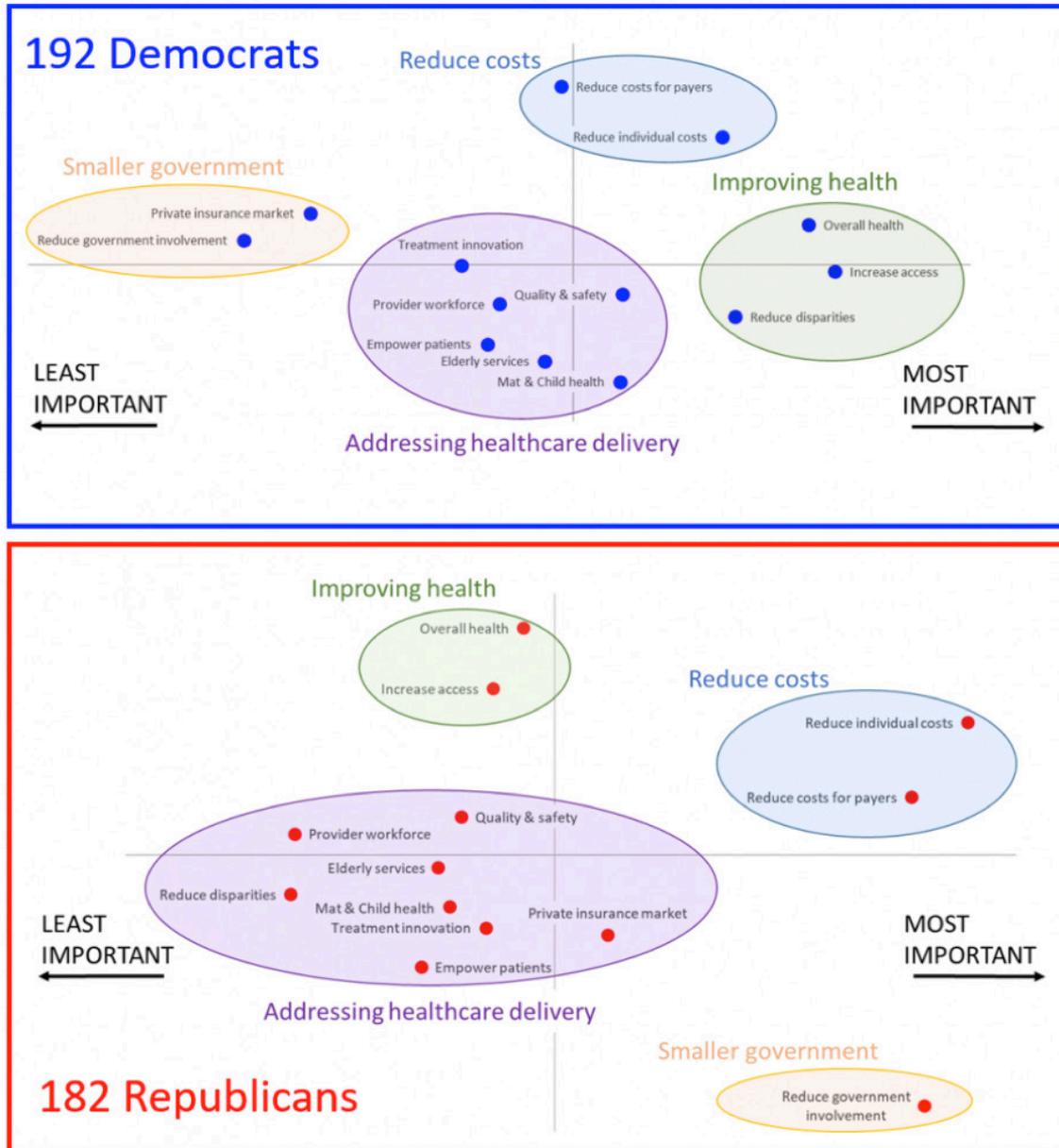
For 10 years, the national focus in health policy has been on the passage, implementation, and potential repeal of the Affordable Care Act (ACA). Fights over the ACA have been highly partisan, including its passage in Congress on a party-line vote and being rejected by Republican leaders in states across the country. These partisan fights have been self-limiting. Efforts to fully repeal the ACA failed in 2017 because they did not gain enough support across the political spectrum to hold even the slim Republican majorities in Congress.

This year, 2018, may represent a shift—or pause—in the partisan tenor of the health policy debate. Actions by Congress and the executive branch have weakened, but not eradicated, the federal template for health care financing and delivery set forth by the ACA. With the encouragement of the current federal administration, much of the impetus for advancing health policy has now fallen on the shoulders of state leaders, creating new openings and new pressures. Although health policy questions remain a top priority in public opinion polling,¹ they may no longer necessarily be seen through the dichotomous filter of being in line with or opposed to the ACA.

Will state health policy leaders be able to navigate the new health reform landscape without falling into the old partisan traps that have tripped up both the left and the right in recent years? Are there new opportunities for cooperation across the partisan divide? What do leaders see as their top priorities?

In 2017, researcher Christina Pagel sent a questionnaire to every state legislator around the country serving on a health, budget, or appropriations committee.² Pagel asked the legislators to rank their priorities from a list of 13 health policy issues or to write in something not on her list. One in eight people replied, giving her a substantial sample of 374 responses almost evenly split between Democrats and Republicans. Pagel used complex, multidimensional techniques to map responses from legislators in each party (Figure 1). She found that Democrats tended to prioritize access and disparities and Republicans wanted to reduce the role of government, with both sides placing a fair amount of importance on reducing health care costs.²

Figure 1. Graphical Representation of Health Policy Goal Rankings by 192 Democratic State Legislators and 182 Republican State Legislators, 2017



Source: Pagel C, et al., 2017. A way forward for bipartisan health reform? Democrat and Republican state legislator priorities for the goals of health policy. *American Journal of Public Health*. <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304023>

The results of this survey raise several questions about the state of health reform. What did legislators have in mind when they said they prioritized the reduction of health care costs? Is there a consensus on an approach to solving this complicated problem? How can we move forward on these policy issues despite the dramatic difference in perspective about the role of government?

In October and November 2017, I visited Denver and Topeka to find out how Colorado and Kansas are approaching this key moment in health reform. The goal of my trips was to dig deeper into the results of Pagel's survey in order to identify barriers to and opportunities for cooperation in this new era of health reform. What would a bipartisan conversation look like in these states?

Colorado and Kansas are ideal case study states for these questions. Both had high response rates to Pagel's survey, allowing for continuity between the quantitative and qualitative components of this research. Both the legislative and executive branches in Kansas are led by Republicans, but the state has a history of bipartisanship. Colorado is trending as a blue state in national elections, but in many ways, it is still very conservative.

Each state has a strong, nonpartisan, independent organization devoted to supporting policymaking on health through convening and providing objective information. This was helpful to me from a practical point of view in that the Colorado Health Institute (CHI) and the Kansas Health Institute (KHI) provided invaluable assistance, such as giving me introductions to policymakers. It also was relevant to my case selection in that these states may be a little further along in having bipartisan conversations because they have had some practice. If cooperation across the partisan divide is possible at the state level, these two states are likely to be good models.

In the two states, I spoke with more than two dozen leaders, including officials from both parties in the legislative and executive branches, as well as key stakeholders, to look for points of consensus (see the appendix for details about my methods). I had the unique opportunity in Kansas to meet with legislators as a group—four Republicans and two Democrats—to talk about bipartisanship in health policy. What I learned in these two states was both disheartening and encouraging. I found a surprising amount of agreement among the policymakers, particularly when they were behind closed doors away from party leaders and the media. Although ideological divisions arose very quickly when the conversation shifted from problems to solutions, nearly all the legislators said they wanted to have a more productive conversation, and they offered many constructive thoughts about how to make this a reality.

A Path to Bipartisanship

This report is more like notes from the field than definitive answers to extremely complicated questions. I heard seven consistent themes from policymakers in Colorado and Kansas, which together show what a bipartisan conversation on health would look like, just how difficult it will be, and how we might get there.

1. The political climate is open to bipartisanship. Both states are in the midst of a major transition in an election year to replace a term-limited governor who has served for two terms. The changing political climate is particularly striking in Kansas, which is

described as effectively having three parties: conservative Republicans, moderate Republicans, and Democrats. The moderate Republicans are rising in number and power, becoming the key players in determining whether conversations move to the right or the middle.

- 2. Frustration over national politics is widespread.** State leaders are unified in their frustration over the challenge of developing state policy in the context of extreme uncertainty and volatility in national policymaking.
- 3. Clashes over the role of government persist.** Even though philosophical differences about the role of government are the biggest obstacles to productive conversations about health reform, they are not insurmountable. Moderate Republicans and Democrats are trying to frame the debate so the focus is not on eliminating government but on ensuring that the government gets value for what it provides.
- 4. There is widespread agreement on the importance of reducing health care costs but not over whose costs to prioritize and what should be done.** Instead, the divisions arise over the key questions of whose costs the policymakers should address, what approaches would truly solve the problem, and the right role for government to take in this effort. Consensus is more likely to develop around smaller-scale, but still highly complicated, ideas such as telemedicine than around broad systemic reforms. The most important next step to addressing health care costs will be to define that consensus.
- 5. Access in rural communities is a priority for everyone.** There is a surprising degree of consensus on the importance of access, particularly when the conversation is centered on geography and provider supply. Health care in rural communities is a major priority for members of both parties, including the fact that Medicaid expansion has become a bipartisan issue in Kansas.
- 6. Focusing on population health may open the door for less divisive conversations.** The legislators voiced strong support for shifting the terms of the debate so that the goal is longer, more fulfilling lives for everybody rather than better individual outcomes or more people covered. The goal of this broader focus is depoliticizing health reform as much as possible, seeking solutions that do not trigger the usual partisan barriers.
- 7. All sides want more strategic thinking and stronger leadership.** The legislators are frustrated by the lack of opportunities to engage in strategic thinking and long-term planning. Procedural realities such as short legislative sessions in Kansas and term limits in Colorado make it difficult for a broad group of legislators to develop bipartisan relationships and deep health policy expertise. Both the legislators and interest groups view the executive branch as uniquely positioned to bring people together.

Political Climate: Ripe for Bipartisanship?

Is bipartisanship on health reform possible at the state level? The answer largely depends on the political context beyond health reform. Both Colorado and Kansas are in the eighth year of a term-limited governor. Of the 36 states holding a governor's race in 2018, 18 are currently served by a term-limited governor. Fourteen of these governors are Republican, many of whom were elected as part of the Tea Party wave in 2010. The 2018 gubernatorial election in these states is a fight over what these eight years have meant and what will come next. Although Kansas and Colorado are experiencing this transition differently, they both are optimistic that bipartisanship may be possible.

Colorado

Colorado is the quintessential purple state. The current governor, John Hickenlooper, is a Democrat, but the state elected Republican Bill Owens to two terms as governor between 1999 and 2007. The state voted for the Democratic nominee for president in the last three elections, but for the Republican nominee in the three elections before those. The congressional delegation includes one Democrat and one Republican in the US Senate, and three Democrats and four Republicans in the US House. Colorado both expanded Medicaid and is running its own health insurance exchange, but it also has a strong culture of individualism and independence that leads it to resist government programs. In 2015, *Newsweek* called Colorado's mix of "God, Guns, and Ganja" the future of American politics.³

The Colorado state house is currently controlled by Democrats, while Republicans have a one-seat majority in the state senate. An industry leader explained the effect of this partisan composition: "Most of our health care policy that is put forward has kind of a liberal bias to it, and the senate is controlled by Republicans, so stuff tends to die there. Consumer bills go there to die. But certainly you can't go too far to the right, otherwise the house would be the place where things die." Current leadership in the state's house and senate have also been open to making deals through compromise on big-ticket issues.

Colorado is described by some as having four parties, with a split on both sides. Respondents view the split on the right as more intense than that on the left, with the left less divided on health policy than on other issues. Bernie Sanders beat Hillary Clinton here by 59 to 40, even though the far left wing of the Democratic Party has had little leverage on health reform after approximately 80% of Colorado voters rejected a single-payer ballot initiative in 2016.⁴

Democrats blame Republican leadership and conservative interest groups for the elusiveness of bipartisan compromise. A legislator in Colorado described being pressed by fellow Democrats on key votes but remarked that it was nothing compared with what his colleagues on the other side of the aisle experience. Republicans who vote against party leaders have been publicly punished by losing committee assignments and becoming targets of right-wing organizations such as the Union of Taxpayers, Principles of Liberty, and Americans for Prosperity. A group of Republican legislators has been dubbed "the

Hateful Eight” because they vote no on everything. Their clout, however, has diminished over the last year, according to some people, and there is more pressure on this group to work on issues rather than just voting no. Colorado has been described as one of the most productive legislatures in the country despite also being one of the most polarized.⁵

Kansas

On the surface, Kansas is a bright red state, with Republicans controlling both the executive and the legislative branches and voting for the Republican nominee in every presidential election since 1968. The then governor Sam Brownback rejected the expansion of Medicaid and, after some internal deliberation, returned federal grants that would have allowed the state to run its own health insurance exchange.⁶ Yet there is a deep history of bipartisanship in Kansas, with the state electing multiple Democratic governors in recent decades. Most notably, Kathleen Sebelius was elected governor twice before moving on to serve as President Barack Obama’s secretary of health and human services. Moreover, the Republican governors before Brownback also tended to be centrists.

The 2016 election dramatically changed the composition of the legislature as voters reacted to the state’s financial crisis. Although Democrats made gains, the greatest change was that moderate Republicans defeated far right incumbents. The lines between the two parties aren’t entirely clear. As one person put it, “There are certain places in Kansas where you cannot get elected without an ‘R’ after your name. So regardless of what your views are, you have to be a member of the party.”

When asked about the political climate in Kansas, people on both sides of the spectrum said that there actually are three parties in Kansas now: conservative Republicans, moderate Republicans, and Democrats. A governing coalition of moderate Republicans and Democrats has occasionally emerged, including on contentious issues such as expanding Medicaid. In fact, a bill to expand Medicaid eligibility as part of the ACA came incredibly close to enactment during the 2017 session, passing the Kansas house and senate with broad bipartisan support but ultimately falling three votes short of overriding Governor Brownback’s veto. As one advocate explained, “More Republicans voted for it than Democrats. That’s a function of there not being many Democrats. But yeah, Medicaid expansion, I think, is a bipartisan issue, absolutely.”

The political culture in any legislature is largely determined by the tone set by its leaders. In some states, the speaker of the house or the majority leader of the senate rules his or her caucus with a tight grip. In Kansas, however—at least since the dramatic 2016 election—legislative leaders have promoted a more cooperative tone. Medicaid expansion is a notable example. For many years, it was impossible even to hold a hearing on the issue. In 2017, legislative leaders maintained their opposition to expansion, but they did encourage a conversation about it. Although they ended up voting against the bill, they allowed the vote to take place.

In summary, 2018 is turning out to be a transition year for both states. Intraparty divisions are playing out in the context of a gubernatorial election that will have a notable effect on

each state's political climate for the next four years. The people I interviewed regularly cautioned me about painting too rosy a picture of the prospect for political harmony in Kansas. Even so, they believed that the moderates are ascending and, with them, the likelihood that bipartisanship and compromise are more likely. The leaders in Colorado said something very similar, that we should not be naive about the division between the parties but also that they have substantial common ground. Under the right conditions, bipartisanship is possible in both states.

Frustration over National Politics

Leaders in Colorado and Kansas are united by their frustration over the volatility of national health reform politics. Last year, 2017, was particularly chaotic, with numerous plans to repeal all or part of the ACA making their way through the US Congress. A Democratic legislator in Colorado told me, "People's hands are up in the air. They're so frustrated. They have no idea what is going on."

Keeping up with and assessing the potential impact of the changing congressional proposals—from the American Health Care Act (AHCA) to "skinny repeal" and Graham-Cassidy—was exhausting. State agencies and stakeholder groups spent a significant amount of time tracking and developing contingency plans. As one executive branch leader in Colorado said, "We have a whole group that has spent months working on the windup of CHIP because you can't not. [They are] developing the mailings, developing the changes, figuring out how to map eligible kids into standard Medicaid, and coordinating on a special enrollment period with the kids that don't map on to Medicaid." All this work was required of state leaders, even though they said they fully expected Congress to renew funding for the Children's Health Insurance Program (CHIP).

The constant contingency planning is demoralizing and exhausting, with implications beyond the policy issue in question. As the same Colorado leader explained, "Those people aren't available to work on other stuff. That is tens of thousands of hours that are being consumed in the name of reducing government in some ways; there's irony there. And repeat that across 50 states."

Uncertainty over the ACA

Leaders in both states pointed to the November 2017 enrollment period for the ACA's exchanges—which was about to open at the time I conducted these interviews—as an example of how the national chaos has affected consumers. An insurance executive in Kansas described this year as one in which companies finally figured out the right prices for this segment of the individual market. "We rated in 2013, and we were under—we didn't appreciate how far we were under in 2014. We used those rates for 2015, so we were still under in '15. Then we didn't quite get caught up in '16, but we think we're caught up now." He went on to point out that this year's rate increases were expected to be moderate but now have to be much higher given the uncertainty created by the Trump administration.

Uncertainty over the ACA's fate was regularly used as a reason for inaction at the state level. For example, Kansas nearly expanded Medicaid eligibility in 2017. As one Republican noted, "All last session it was like we can't expand Medicaid because it's all going to be repealed." She further explained that in order to move forward with confidence, states need "some solid answers from the federal government about their role—do we have Obamacare, or do we not have it?"

Several people I interviewed mentioned the lessons learned from watching other states negotiate Medicaid waivers. A conservative leader in Kansas' executive branch said that he was excited by signals that the Trump administration would be more flexible in approving Medicaid waivers but has not seen any indication yet that this is true. So far, "it's a little bit like they're talking a good game." A leader in Colorado's executive branch said the same thing: "They say they are going to give flexibility, but they may just be lying.... Really? You turned down Iowa for everything that the Republicans have been asking for? Oklahoma's nonresponse? I just don't think you can take anything at face value." Waiver approvals made by the Trump administration after these interviews were conducted, such as adding work requirements in Kentucky and Indiana, suggest that states will indeed have significant flexibility. But they are not sure what the lines are and whom to trust.

States as Innovators

Legislators and interest group leaders said that, over time, they have dealt with the constant uncertainty by tuning it out. As described earlier, state agencies did not have that luxury. The leader of a stakeholder group in Kansas told me, "I think, by and large, folks have dialed out—tuned out the discussion in DC, because they don't see any progress; they've disengaged.... We're a small state in the big cacophony of federal health care policy, so I think a lot of people are resigned. What's going to happen is going to happen, and let us do the best that we can do with the resources that we have here."

Even so, leaders in both states said they believe that the states have an important role to play in the development of health policy. If anything, they feel that the chaos at the national level elevates the importance of the states. A Kansan legislator summarized this view, saying that state leaders try not to be overly concerned about federal uncertainty because they believe in the states' own ability. "I really think that states have the ability to innovate much more easily than the federal government does, and each state faces a lot of the same issues. But our demographics are different. Our economics are different. So, if we can find the solution that fits Kansas, that should be our basic philosophical approach, versus trying to emulate somebody else that has a different set of circumstances driving their decision making."

The Role of Government

One of the most striking findings from Pagel's survey of state legislators is the stark difference in perspective on the role of government in health care. The Republicans insisted that reducing the government's role was their first or second highest priority, whereas the Democrats ranked it last in importance. Leaders in both states told me the same thing, describing this philosophical difference as the greatest single obstacle to developing bipartisan health policy.

A conservative leader in Kansas maintained that every problem in health care could be traced back to and blamed on the government. A conservative member of the Colorado House of Representatives was appalled that the legislature passes hundreds of laws every year, feeling that government should be getting out of the way rather than asserting its role. Leaders in both states described a culture of "rugged individualism" in which people are proudly independent and self-sufficient.

Democrats described being frustrated by the intense focus among Republicans on the role of government. A legislator in Colorado observed, "I tend to think that they are so deeply rooted in their views of how things should be that sometimes they don't recognize how things actually are." An interest group leader in Kansas said, "I don't think a lot of them have any awareness of how involved the government is in health care now. And so getting the government out of health care is like changing the entire system. It's not an easy thing to do. Everybody wants the government out of health care, except for Medicare, and nobody considers the tax break they get for their employer providing insurance as some benefit they're getting from the government. And so I don't think there's a really big understanding of that, which is why this is so complicated."

Other Democrats noted that they were frustrated by the dichotomy of big and small government. Said one, "I'm not sure we're as far apart sometimes on the issue of small government, because who really wants to advocate for big government?" The leader of a foundation added, "None of us are advocating for big government, but we get immediately locked into 'you want government support, and we want private support.' And then we stop right there."

The conversation about the role of government in Colorado is complicated by the large number of stakeholders participating in health reform conversations. The insurance and hospital industries have no clear market leader. As a leader in the executive branch put it, "I think each health plan in Colorado has roughly a 20% market share. While they are aggregated, the hospitals are not like a Sutter [Health] in Colorado." Another executive branch leader observed that the same is true for nonprofit advocacy organizations: "There are a lot of different organizations and foundations. There is no cohesive point for advocacy; they all are sort of on their own page."

The Right Role for Government

A significant number of people on both sides of the political spectrum said they were more open to constructive dialogue than the other side might realize or than is portrayed in the media. This view tended to belong to people who maintain that government is already deeply involved in health care and that this involvement is not going to change.

Several ideas were proposed for bridging the divide between the parties. First, some people in Kansas tried framing the Medicaid expansion as an opportunity for the state to get its fair share of federal dollars. They argued that it was not right for the state's residents to send tax dollars to Washington, DC, but to let all the money go to other states. This argument did not resonate with advocates of small government, who noted that they would rather the federal government not take and spend so much money in the first place.

Others called for reframing the conversation so that the focus would not be on how to get the government out of health care but, rather, how to maximize value given that the government's role could not be eliminated. As an interest group leader in Kansas pointed out, "It isn't about government, is it? I guess the question is, what is the appropriate way for government to be involved?" This is a subtle distinction but one that people hoped would relieve the tension. States must balance their budgets, and they want to get a high return on the money they spend, whether in monetary savings or better health.

There were some indications that this revised framing appeals to Republicans. As a conservative interest group leader in Kansas told me, "I come from the Koch network and am pretty pure free market, but [the role of government in health care] isn't going away. We might as well make it work. It wouldn't be more government involvement, but the government involvement we have—let's have it be more effective." This framing is particularly palatable in Kansas given the dire fiscal climate resulting from many years of tax cuts in the name of less government. Indeed, the appropriations for the state's agencies have been cut so much that extensive institutional knowledge has been lost, and the agencies are struggling to carry out existing programs. Some Democrats are afraid that reframing the conversation in this way would give up some ground to Republicans. But a leader in Colorado's executive branch suggested that it is in the "Democrats' best interest to simply recede from the question of what the role of government is and to accept a more limited perspective that allows government to be involved as a facilitator rather than a leader."

The key takeaway on this point is that differences over the role of government are deep and perceived as the biggest obstacle to bipartisan compromise on health reform. But this difference can be overcome by agreeing on the problem, by identifying issues of common concern. The key question then becomes, which issues do leaders in Colorado and Kansas believe are most likely to attract bipartisan attention and bipartisan solutions?

Reducing Costs

The results of Pagel's survey suggest that bipartisan agreement may be most likely in regard to health care costs. During each interview, I described the survey and asked whether the interviewee agreed with there being widespread agreement on the importance of costs. Leaders responded universally that this was consistent with what they would expect. As the head of a stakeholder group in Kansas explained, "That doesn't surprise me. Who is against reducing costs? There's nobody who can look at health care and say that the costs are reasonable, right? Everybody will tell you they're out of control." A Republican legislator in Kansas added that there was widespread agreement that "escalating health care costs are really just outrunning inflation and any growth and increase in productivity that the economy would be able to support."

But these conversations reveal a deeper divide on the health care costs than the results of Pagel's survey might indicate. As the leader of an interest group in Colorado put it, "I would say that the nation has had a consensus on needing to control health care costs since the '70s. How to get there—there is not consensus anywhere." Political will in Colorado over the last decade has been sufficient for the government to convene task forces and commissions to study the problem of high health care costs and offer recommendations. Nonetheless, despite the presentations and reports over the past few years,⁷ very little has been acted on. One leader noted that the task force commission was not successful because the problems of cost are so much more difficult to define and solve than the topics addressed by previous commissions, such as providing broader access to health insurance.

Yes, but Whose Costs?

At the heart of this disagreement is a lack of clarity over whose costs policymakers should focus on, as there are many ways to conceive of the problem based on who is paying. The focus could be on reducing the amount spent by government through programs such as Medicare and Medicaid. It could be the price of health care for consumers through premiums, deductibles, and cost sharing. Or the focus could be on the tension between the costs borne by hospitals in the delivery of health care compared with what insurers are willing to reimburse given their own costs. There is also the total cost of health care to the economy, which is somewhat difficult to untangle given that health care is also a major source of jobs and economic growth.⁸

These differences were not lost on the policymakers I spoke with, as a number of people worried that others were shortsighted or had too narrow a focus. As a Democrat in Colorado explained, "There is a fundamental difference in how cost is defined. Republicans are focused largely on price, not cost." An interest group leader in Kansas expanded on this distinction, saying that "one group is focused only on the cost to the government and may not be as sensitive to the cost to the consumer, or the citizen, as they probably should be. The other group is probably more concerned about the cost to the citizen, the consumer, and thinks that the role of government is to be able to help provide care to its citizens."

In other words, while everyone agreed that the amount paid by consumers was a major problem, a handful felt that this was symptomatic of a much deeper issue and that the system was fundamentally broken. For example, a leader in Kansas explained that it was a mistake to concentrate too much on issues like malpractice claims and pharmaceutical profits because “the nitty-gritty of it is that health care is expensive.”

According to this last comment, consensus on the importance of reducing health care costs breaks down when the conversation shifts to solutions because they are not beginning from a shared understanding of what problem needs to be solved. People who emphasized affordability and the price of health care to consumers also tended to emphasize market-oriented solutions directed at helping consumers make better-informed decisions.

Increasing the transparency of health care prices was described as a priority for leaders in both states, with the expectation that more competition would improve quality and drive economic efficiencies, thereby lowering costs. Hospital leaders and some legislators were skeptical, though, that greater price transparency would lead to substantial changes in costs. The Democrats who talked about transparency tended to be less focused on consumer-oriented initiatives and more focused on better understanding the systemic problems in health care financing. As one industry leader in Colorado explained, “Frankly, on consumer transparency, the evidence isn’t there. Consumers don’t use it. But the perception is that the industry is trying to hide something.” The evidence agrees with them, according to a recent study in *JAMA*, which found that very few consumers use price transparency tools when they are available and that their use was not associated with lower health care spending.⁹

Those who felt that the root cause of rising costs was a broken health care system were less engaged in talking about specific proposals. They considered the problems so large that they felt powerless and were skeptical about whether states could ever solve these problems. In some cases—including some Republicans in Kansas—the people I interviewed supported delivery system reforms and a shift away from fee for service, but they did not see the role of state government as driving these changes.

In summary, there is a consensus that the cost of health care is a major problem but little agreement on what the problem is or what should be done. Leaders across the political spectrum agree that the most important next step might be coming to an agreement on the definition of the problem. The ideas most likely to lead to a broad agreement are those that work within the current system rather than trying to restructure and rebuilding it. These include the focus on transparency already discussed, as well as expanding telemedicine to improve access to care in rural communities. It was while pursuing this line of questioning with the focus group of Kansas legislators that our conversation took a turn I did not expect: the surprising degree of consensus on the importance of access to care.

Access in Rural Communities

After describing the results of Pagel's survey to the panelists, I expected that they would agree that cost was the issue most likely to unite the parties. Instead, they rallied around the importance of access to health care. And it was not just the two Democrats in the room who felt this way. Republicans also spoke up, saying things like "It's all about access" and "I think here in Kansas, access is probably the most important." I followed up with questions about what exactly they meant given the many dimensions of access such as insurance and geography.

These legislators said the survey may not have picked this up because when people hear the word "access," they tend to think of insurance and the ACA. The dominant sentiment was that it was important to overcome geographic barriers to access in rural communities. One way this concern manifested itself was through anxiety about the supply of providers, that there simply were not enough doctors working in their communities to meet the population's needs. Moreover, the current rural workforce is aging without signs that a new generation is ready to move in.

Legislators also expressed anxiety over hospital closings, another issue that touches on access to care in rural areas. This concern extends beyond health care, as it has major implications for the local economy in these communities. For example, even a small hospital is often the largest or second largest employer in a rural region. One legislator in Kansas told me that keeping these hospitals open "may be a key to many small towns staying viable."

Colorado has two different types of rural communities, those located in highly affluent resort towns and those in remote farming and ranching communities. Both have their challenges, but the struggles are different. For example, hospitals in resort towns need to have the technology and staffing to maintain a level-3 trauma unit so they can handle the winter crunch. This results in significantly unused capacity most of year. Some leaders in these communities do not feel they are getting adequate support from the state to maintain these facilities. They feel this is problematic given that tourism is such a major part of Colorado's economy, because if it's good for their towns, it is good for the state, as several interviewees noted.

One of the most contentious, yet successful, bills in recent years in Colorado was framed specifically to support hospitals in rural communities. The state collected a fee from all hospitals and then redistributed the money primarily to rural hospitals and those that served a large proportion of Medicaid patients. A proposal to change how the fee interacted with the state budget generated extensive debate for years but nonetheless resulted in a bipartisan bill being enacted in May 2017. The compromise was seen as preventing hospitals from closing in rural communities, as well as providing more money for roads and schools in those communities. A Republican member of the Colorado house described the end result in this way: "Each side had different asks going into this, and I think because we're both not smiling really big; we both love and hate pieces of this—which is exactly where it should have ended up."⁹

Medicaid Expansion as a Rural Issue

Although the starting point on access for many Republicans in Kansas is to center on geography and workforce, the concern in Kansas over barriers to care in rural communities is so acute that some of them made the jump to advocating for expanded access to insurance. One Republican stated that rural hospitals are struggling so much because there is so much uncompensated care. A fellow legislator in the focus group explained that urban and suburban hospitals are dealing with the same issues of uncompensated care but that the effect was greater in rural areas because the margins were smaller.

This is why, they explained, Medicaid expansion has become a bipartisan issue in Kansas. Enough Republicans in rural districts have become convinced that the way to save their hospitals is to increase the number of people with insurance, even if that means cooperating with the federal government on Obamacare.

Not everyone on the right agrees that the problems of access to care in rural areas justify expanding Medicaid. One conservative leader believes that a hospital that recently closed would, most likely, not have been able to stay open even if the state had expanded Medicaid years earlier. She argued that most of the Medicaid money would go to a small number of hospitals in three urban areas and that rural hospitals would receive very little.

When asked whether Kansas would expand Medicaid during the 2018 session, there was near-universal consensus that the then lieutenant governor, Jeff Colyer, was the key factor. The composition of the house and senate did not change between 2017 and 2018, so it is unlikely that the legislature would have enough votes to override another veto. Colyer was in the midst of his own first-time election and gave little indication that he would respond differently than his predecessor. In the face of these odds, the legislature did not pass an expansion bill in 2018.

Health as the Goal

Population health was another issue that generated significant support from leaders on both sides of the political spectrum. A Republican legislator in Kansas put it this way: “When you look at the big leaps in human longevity, it’s really simple things like sewer systems, clean water [that make a difference].” By contrast, she noted that more attention is going to health care technologies that are enormously expensive even if they improve health only marginally. “So, really a fancy new heart stent wasn’t the thing that was just going to be a game changer for health care in our country? Yeah, it’s not.”

As another person in Kansas explained, “We will never treat our way out of the chronic disease crisis our country is facing. We can’t write enough prescriptions, so we have to go upstream and look at the health of our community. What’s the health of my family? What’s the health of my company? When you start getting conversations like that rolling, that can be helpful.”

Many people in both states, including policymakers on the left and the right, expressed strong support for broadening the conversation about health reform to make it clear that the overarching goal is health. One way I posed this question was to ask the interviewees to imagine that 10 years from now their state was the healthiest in the nation. Then I asked them to reflect on how they got to this point. A number of people in Colorado pointed out that they already were one of the healthiest but that deep disparities still existed, such as those between urban and rural communities.

One common sentiment was that we should avoid jumping too quickly to talking about what to do before we know clearly what the problem is. As a leader in Colorado's executive branch maintained, "The first step when you say the healthiest state is then to define that with a discrete set of population health measures, because that can't be all things to all people." A leader in Kansas suggested trying to have a conversation in which the ground rules are to not talk about any solutions but to focus entirely on shared values and end goals: "Let's talk about what a healthy community means to all the values that we hold dear in being a part of America."

Government as the Leader in a Nonpartisan Conversation

Nearly everyone I interviewed said they supported a focus on health rather than health care, because it opens the door to a conversation that does not immediately put up a partisan wall. Republicans and Democrats agreed that a focus on health more broadly allows the government's role to extend beyond running expensive programs and handing out entitlement benefits. That is, the government can be both a leader and a convener, connecting communities with needs to available resources for meeting those needs. It can partner with the private sector and local leaders to develop solutions rather than mandating and pushing.

A physician in Kansas mentioned Iowa, which has had an initiative for many years centered on becoming "the healthiest state." When visiting Des Moines, he was struck by the extent to which Iowa's focus on being the healthiest state was a part of their culture. "I think that when you start embedding issues of public health into fundamental core blocking and tackling government questions, then you can start making changes that help lead to a healthier community. When you have those kinds of conversations, then it seems natural to have business, providers, consumers, and policymakers all get together and say, 'Then how can we take this to the next level?'"

Skepticism of Broadening the Focus

I am not the first researcher to hear state leaders say they want to pay more attention to upstream factors affecting population health. In 2016, Erika Rogan and Elizabeth Bradley asked policymakers why states devoted so few resources to social services relative to health despite widespread agreement that flipping this ratio is more likely to produce better health. They uncovered three major issues: (1) population health is not as high a priority on

the public policy agenda as other issues, because of either minimal attention by policymakers and the media or measurement complexities; (2) financial and political incentives to improve health are misaligned, including that policymakers are looking to the next election cycle, whereas improvements in health require long-term investments; and (3) there is no agreement about who is responsible for health.¹¹

I found the same barriers in Colorado as in Kansas, with policymakers warning that concentrating on population health would meet the same fate as emphasizing health care costs: consensus would break down when they moved from talking about the problem to solving it. A leader in Kansas cautioned that this was “going to run right into the rocks of the conservative, moderate, liberal divide.” A leader in Colorado said the same thing: “You still get down to a fundamental question of what the role of government is, and that is a huge divide between the parties.” A leader on the far right confirmed these worries, saying that the government’s playing any kind of leadership role is overstepping, even if it is just as a convener and not spearheading legislation.

Some conservatives are incorporating population-health language into their proposals in ways that are not entirely comfortable for liberals. For example, Kansas Governor Jeff Colyer has tried to appropriate the language of the social determinants of health to fit within a conservative mind-set. In his proposals for Medicaid reform, he coined the phrase “the Social Determinants of Independence” to promote “personal plans that are tailored to an individual’s vision for their good life.” These include having a career path, being an active member of a community, and having friends and making emotional connections.¹² It is unclear not only how to make this idea work but also whether Democrats would be comfortable doing this.

Democrats in Kansas were skeptical to begin with about whether there was enough will and capacity in their depleted government agencies to devote the attention and resources needed for this kind of initiative to succeed. The lack of will might prevail even if Kansas were running at full capacity. As the leader of a stakeholder group there lamented, “Kansas is always pretty content to be in the middle. If you look at national rankings on anything, as long as we’re between 20 and 30, it’s good. If we’re at 10, we must be spending too much money. And if we’re at 40, we don’t want to be down with Mississippi and Arkansas. And so it always annoyed me that we were content with the middle, because nobody really wanted to push.”

Despite these obstacles, it was striking how readily leaders on all points of the political spectrum agreed on shifting the health reform debate to consider population health more specifically. When asked about this, a few people pointed to their state’s health foundation as helping direct this conversation. They also had a widespread desire for more research and guidance on overcoming these barriers.

Visionary Governance

One of the most common themes in these interviews is legislators' frustration with the lack of opportunities they have to engage in strategic thinking and long-term planning. As a Republican legislator in the Kansas focus group explained, "Government is always reactive but very rarely visionary.... No one is looking forward." Time is too limited, and attention spans are too short.

I detected structural barriers in each state that were preventing the policymakers' development of expertise. As another Republican at the Kansas focus group observed, "I'm a process-oriented person, and the way this system operates restrains us from effectively addressing these big issues, because these big issues are so complicated. You're not going to be able to find, I think, a reasonable solution in 90 days the way this [system] is set up."

Similar concerns were voiced in Colorado, where a term-limited citizen legislature is paid just \$30,000 per year to be in session for four months, giving them very little time to fully develop an expertise on policy issues. A leader in the executive branch complained that "in a term-limited legislature, the people who have the real institutional knowledge are the lobbyists."

Consider the conversation that could take place, as some interviewees proposed, to determine the goals of a focus on population health. Who would participate in this conversation? Who would facilitate it? When and where would this take place? The leader of a stakeholder group in Kansas suggested that "Switzerland entities" like hospital associations could help facilitate such conversations. Others expressed skepticism about whether these groups were truly neutral or would even be likely to engage.

Many people said they trusted their state's health research institute to effectively carry out the role of facilitator. Both Kansas and Colorado are home to a health institute, a state-level nonpartisan organization based on research and providing information to policymakers and the public. There was near-universal praise for the Colorado Health Institute (CHI) and the Kansas Health Institute (KHI), both of which were described by the interviewees as independent, trustworthy, unbiased, and nonpartisan. A legislator in Colorado stated, "CHI is awesome. In addition to just always being available to answer questions, they do a ton of outreach stuff at the capitol and try to make themselves available." This person went on to complain about not having adequate legislative staff, saying that instead, he picks up the phone to ask the CHI for research.

On the other side of the political spectrum, even the most critical and far-right legislators I interviewed in Colorado praised the CHI, appreciating its role in facilitating conversations and providing unbiased and accurate data: "I don't think they're pushing an agenda." Legislators on both sides of the aisle offered the same level of praise for the KHI.

Further research is needed to fully understand how organizations like the CHI and the KHI can more effectively facilitate conversations and strategic planning among legislators. The demand is clearly there. Bringing people together more often to develop a shared understanding of problems would not be enough, but it would be a positive step toward bipartisan health policy. An interest group leader in Colorado described the importance of having more frequent and more productive conversations: “The interpersonal relationships are also really huge, and so sometimes it’s more of a factor of who you’re working with than what party they belong to.”

Conclusion

My conversations with more than two dozen leaders in Colorado and Kansas provide a window into the health reform struggles and opportunities with which state leaders are currently grappling. This was an opportunity to dig deeper into the valuable insights gained from Pagel’s survey in early 2017. The answers to my questions enabled me to take Pagel’s survey one step further, by gaining insights into both what the respondents meant and how they should move forward. Pagel’s results suggested that Republicans and Democrats share a focus on reducing costs but had very different perspectives on the role of government. What this survey did not do was tell us what the respondents actually meant and how they should move forward.

I began my conversations hoping to identify a path to consensus on reducing costs but left disappointed on that front. Legislators and other state policy leaders have such divergent views on what the problems and their root causes are—to say nothing of their disagreements on solutions—that the most important next step would be to agree on a clear definition of the problem. Republicans tended to lean toward prices and how to make health care more affordable for consumers. Democrats wanted the same thing but said that health care could not be made more affordable without drastically changing the system. They argued that health care in the United States is fundamentally broken and that market-oriented solutions simply put Band-Aids on problems rather than truly solving them.

But I did find hope that Republicans and Democrats are not as far apart on some issues as Pagel’s survey and the current media narrative might suggest. For example, I expected to see division on how to improve access to care. Republicans at the national level have not stressed insurance coverage in their attempts to repeal the ACA, and Democrats were much more likely to respond to Pagel’s survey by noting that increased access is a priority. I heard leaders on both sides in both states, however, emphasize the importance of access. In fact, the focus group in Kansas named it their top priority. The agreement became more pronounced as the conversation shifted from talking about insurance as a means of increasing access to addressing geographic barriers and the challenges of providing health care in rural communities.

In fact, health and health care in rural areas was a major theme that kept coming up in my interviews. Policymakers saw the partisan conflict in their state as a reflection or even a proxy for the divide between rural and urban/suburban communities. Rural residents feel that their needs are being swallowed up by the interests of the Denver and Kansas City metro areas. Health care leaders contend that the issue is even bigger than health care, since hospitals are one of the dominant economic drivers in rural communities. This narrative is powerful. Both states have recently made bipartisan progress on a major, albeit contentious, reform—the provider fee bill in Colorado and Medicaid expansion in Kansas—driven by its framing as a boost to rural hospitals.

I also heard widespread agreement that the current partisan debate over health reform is not satisfying or productive. Leaders on both sides expressed frustration with the volatility of national politics and the countless hours that have been spent tracking ACA repeal bills in Congress and considering contingency plans. Even people who opposed the ACA said they hoped for greater stability and predictability from the federal government.

In addition, I found extensive agreement that the greatest obstacle to bipartisanship was the divide between what the parties see as the proper role of government. But nearly everyone I spoke with said they hoped for greater bipartisanship and were willing to work to make that happen. The key might be to aim for depoliticization and nonpartisanship rather than bipartisanship, deemphasizing the degree to which policies were mapped onto entrenched partisan frames. For example, Democrats hoped the debate could move away from whether a proposal indicates big or small government and could focus instead on ensuring the correct role for government. They argued—and many of their Republican counterparts agreed—that it would be impossible and undesirable to completely remove the government from health and health care. As a result, we should concentrate on how to get the most value from what the government is doing.

One of the most striking differences between the results of Pagel's survey and what I heard in these conversations is the broad desire for a greater focus on health and health outcomes. Most leaders on both sides wished, or at least supported the idea, that the terms of the debate be broadened so that the goal was health, not health insurance or health care. The issues of costs and access would still be important, according to the interviewees, but more attention would be paid to addressing the biggest causes of mortality and morbidity, such as suicide, opioids, and chronic disease. Republicans liked this framing because it would allow the government to use its leadership role as a convener and a facilitator rather than just an administrator of programs, which is how government is viewed in most current conversations.

One of the themes I heard most often was that leaders wished they had more time and space for big-picture thinking and strategic planning. Many people thought that their conversations jumped too quickly to solutions before they all understood the problem they were trying to solve. They hoped as well that more legislators would engage with state-level organizations like the Colorado Health Institute and the Kansas Health Institute to have such conversations.

Again, my guiding question: is bipartisanship on health reform possible at the state level? The clear answer from these conversations is yes, but we should not think naively that it will be easy or take place on its own. A more productive conversation is possible only if both sides are willing to come together and also to give up some things. This will not happen without someone stepping up and leading the way. Even though legislators and stakeholders are looking to the executive branch for leadership to use its unique resources to bring people together, outside organizations could serve as independent facilitators and providers of evidence. The political climate in these two states is in the midst of a great transition—particularly in Kansas, where the moderates are ascending—but it nonetheless seems that the direction in both states is conducive to bipartisan conversations.

Appendix

A Note on Methods

I interviewed 27 people between October 18 and November 3, 2017—11 from Colorado and 16 from Kansas. Most of the conversations took place in person in Denver and Topeka, although I did speak with some leaders by phone to make sure to include legislators whose districts were too far from the capital city for me to meet them in person. In both cases, I was able to speak to someone in the lieutenant governor's office, leaders in key agencies, a diverse range of legislators, and the leaders of important stakeholder groups such as insurance carriers, hospitals, providers, advocates, and health foundations. In exchange for their candor, I did not reveal the interviewees' names. I lightly edited the quotations for space and clarity.

I had the unique opportunity in Kansas to conduct a focus group of state legislators in which four Republicans and two Democrats, including members of both the house and the senate from different parts of the state who serve on committees that influence health policy, sat around a table for 90 minutes and had a conversation about my questions. This breakfast meeting took place at the offices of the Kansas Health Institute, directly across the street from the Capitol Building in Topeka. This group conversation was largely possible because my visit coincided with meetings of the interim session of the Special Committee on Health regarding telemedicine. In order to comply with the open-meeting ethics rules that prevent official government business from taking place outside public meetings, our focus group conversation did not dwell on telemedicine, the topic that was on the committee's agenda later that day. I also tried to convene a similar focus group in Denver, but the interviewees' schedules made this impossible.

I am extremely grateful to the leaders of the Colorado Health Institute, particularly Allie Morgan, and the Kansas Health Institute, particularly Bob St. Peter and Linda Sheppard. Both organizations provided invaluable assistance by introducing me to the key leaders, orienting me to the lay of the land, and providing space for me to conduct interviews with anyone who wanted to meet outside his or her office. Indeed, this project would not have been possible without the support of the CHI and the KHI.

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