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You Can't Make Me Do It: State Implementation of Insurance Exchanges under the Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) of 2010 has been one of the most controversial laws in decades. The ACA relies extensively on the cooperation of states for its implementation, offering opportunities for both local adaptation and political roadblocks. Health insurance exchanges are one of the most important components of the ACA for achieving its goal of near-universal coverage. Despite significant financial support from the federal government, many governors and legislatures have taken actions that have blocked or delayed significant progress in developing their exchanges. However, many state commissioners of insurance have played constructive roles in moving states forward in exchange planning through their expertise, leadership, and pragmatism, sometimes in spite of strong political opposition to the ACA from governors and legislatures.

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exchanges within specified deadlines. First and foremost among these decisions, states have had to decide whether to create their own exchanges or to rely on the federal government to create one. These decisions will likely have a major impact on how effective the exchanges will be in contributing to the ACA's goal of near-universal coverage.

In terms of public administration research, the ACA offers a natural experiment for investigating the political and organizational factors affecting state-level implementation of a federal mandate. The requirement to create the exchanges can be thought of as a common shock to state governments: simultaneously, all states had

to engage in implementation of a substantial and complicated policy. Although a few states already had institutions in place that could be incrementally changed to meet the ACA requirements, most states had to start from scratch. These states vary in terms of the support for the ACA expressed by their governors and legislatures, ranging from avid support to legal challenges. The states also vary in terms of the capacities of the offices of their commissioners of insurance, which regulate insurance and generally play a lead role in designing the exchanges. The contemporaneous efforts of the states provide an opportunity for sorting out the relative importance of political position and administrative capacity in timely implementation of the exchanges.

We explore these issues in the following sections. First, we begin with an introduction to the concept of insurance exchanges as set out in the ACA. Second, we describe the various ways in which the states have responded, in terms of both general strategies, ranging from full compliance to outright refusal, and specific choices about institutional features. Third, we present common themes that have emerged during

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The Patient Protection and Affordable Care Act (ACA) of 2010 has been hailed as a legislative landmark, comparable to the establishment of Social Security in 1935 and Medicare in 1965. Its history and development have been extensively described in many places (see, e.g., Haeder 2012). A variety of historical, political, and legislative necessities resulted in the ACA relying extensively on state governments, delegating to them significant responsibilities for implementation. Although this is consistent with the long-standing federalist tradition in American welfare policy, delegation also provides a variety of venues for opposition, as several important components of the ACA require state action. While complying with the Medicaid expansion has the greatest fiscal implications for states, the establishment of health insurance exchanges to facilitate the availability of health insurance options for individuals and small businesses poses the greatest administrative challenge. States have had to make a number of decisions about the institutional features of their

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the implementation process. Fourth, we illustrate the important role that state commissioners of insurance have played in moving implementation forward in the face of adverse politics. Fifth, we discuss how many states may be further along in the implementation process than commonly thought. Finally, recognizing that the ACA “has now survived two near-death experiences” (Nather 2012), we present an outlook for the future of insurance exchanges. We note that the implementation process is a moving target, and our presentation includes developments up to February 2013.

Health Insurance Exchanges and the ACA

The ACA provides consumers with a wide variety of new protections and benefits to be phased in over the rest of the decade, including guaranteed issue and renewal, minimum medical-loss ratios, the elimination of annual or lifetime caps, and the standardization of administrative processes. A potentially much more important component of the ACA is the requirement that states establish health insurance exchanges.

Health insurance exchanges are marketplaces for individuals and small businesses that facilitate the purchase of insurance by increasing competition, transparency, and efficiency. The U.S. Department of Health and Human Services (HHS) specifically defines an exchange as “a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality” (HHS 2011). In January 2013, citing concerns for non-English speakers, the Barack Obama administration officially decided to rebrand the exchanges as “health insurance marketplaces.”

Prior to the enactment of the ACA, various forms of insurance exchanges had been operational, including, most prominently, the Massachusetts Health Connector, the Utah Health Exchange, and California’s defunct PacAdvantage. The concept has long been advocated by the conservative Heritage Foundation, and it was a mainstay of many Republican health reform proposals prior to the ACA. In the past, however, various exchanges suffered from adverse selection problems and ultimately succumbed to the ensuing “death spiral” of ever-sicker customers (Gardiner 2012).

Following passage of the ACA, California was the first state to establish an exchange in full compliance with the ACA on September 30, 2010. The exchange created by the California legislature significantly exceeded federal requirements, and it was followed by the establishment of exchanges in West Virginia and Maryland. According to the Congressional Budget Office (CBO 2011), exchanges will provide coverage to 9 million individuals in 2014 and 23 million by 2017. The same report predicts that 2.6 million small business employees will receive coverage through an exchange in 2014 and 3.7 million employees in 2017. The PricewaterhouseCoopers Health Research Institute (2011) estimates that exchanges will account for \$60 billion in health insurance premiums in the first year and nearly \$200 billion by 2017. So far, the HHS has disbursed more than \$3.5 billion in grant funding to support planning for exchanges.¹

Establishment of Insurance Exchanges

At the most basic level, a state must decide whether to establish its own exchange or to rely on the federal government to provide

one. Under the ACA, state exchanges (called American Health Benefit Exchanges) were to be certified by January 1, 2013, by the HHS secretary and established no later than January 1, 2014, to “facilitat[e] the purchase of qualified health plans” (§ 1311[b]). By the same date, states must also have established a Small Business Health Options Program (SHOP) “designed to assist qualified employers [i.e., those with fewer than 100 employees; § 1304(b)(2)] in the State . . . in facilitating the enrollment of their employees in qualified health plans offered in the small group market” (§ 1311[b]). However, states may initially limit participation to those employers with fewer than 50 employees (§ 1304[b][3]). States may combine both functions or utilize separate entities. All members of each program are treated as a single risk pool unless determined otherwise by the state (§ 1312[c]). By 2017, states may open up exchanges to larger employers as well.

If a state fails to comply with these requirements, then the HHS secretary is charged with the establishment and operation of the exchange (called Federally Facilitated Exchanges or FFEs; § 1321[c]). Guidance provided by the Centers for Medicare and Medicaid Services (CMS) in November 2011 offered states significant leeway in the establishment of exchanges. Moving away from the strict deadlines of the ACA, the CMS provided states with more options, including various degrees of partnerships with the federal government (Partnership Exchanges) for components of the exchange, such as information technology (IT) systems. According to further guidance issued by the HHS, under the federal–state partnership model, the federal government will handle consumer enrollment, operation of exchange call centers, certification of qualified health plans, technical assistance, and consumer subsidy determination. State partners may choose to take responsibility for qualifying health plans for exchange participation, setting up rules for brokers and agents, and providing consumer assistance. However, the “HHS, by law, retains authority over each FFE” (Center for Consumer Information and Insurance Oversight 2012, 6). FFEs will initially employ an open-market model, accepting all health plans meeting minimum qualifications and utilizing traditional health insurance brokers and agents (Center for Consumer Information and Insurance Oversight 2012). However, health plans participating in an exchange will be responsible for meeting both existing state and federal requirements. States may also take over federally established exchanges after a period of time. Moreover, states without fully functioning exchanges can become “conditionally” certified in 2013. States will continue to be the primary regulator for insurance plans, even in a federal exchange. States will also be able to obtain grant funding through 2014 for both state and partnership exchanges.

Governance and Administration of Insurance Exchanges

States have been granted significant flexibility in the establishment of their exchanges. First, exchanges can be created as either a government agency (either within an existing agency or as a stand-alone entity) or a nonprofit organization (§ 1311[d][1]). States may also establish regional exchanges that operate in multiple states (interstate exchanges) or within select regions of a state (subsidiary exchanges) (§ 1311[f][1]–[2]), although, interestingly, no state appears to be moving in either of these directions. However, several New England states have cooperated in their efforts through a consortium supported by an Early Innovator Grant. States, with

certain limitations, may contract out various responsibilities of the exchanges to third parties (§ 1311[f][3]). Exchanges must be self-sustaining by January 1, 2015, and may assess user fees to participating health plans or other measures in order to achieve that goal (§ 1311[d][5]). States are encouraged to consult with a broader base of stakeholders in the development and operation of their exchanges (§ 1311[d][6]). Although exchanges are subject to a variety of financial integrity requirements (§ 1313), the ACA is silent on the specific governance structure that states may decide on for their exchanges, including whether they should be operated as agencies or commissions. States have to decide whether to require insurance plans to provide the same plan options inside and outside the exchanges and what roles agents and brokers are supposed to play. Finally, states must decide whether their exchanges should act as active purchasers or take a more passive role as a mere clearinghouse or marketplace.

Insurance Exchange Functions

A variety of minimum requirements are included in the ACA regarding the operation of exchanges. Functions of the exchange must, at the very least, include the certification, decertification, and recertification of qualified health plans (QHPs), the operation of a toll-free service hotline, the maintenance of a Web portal, the rating of each qualified health plan, and the provision of standardized and simple enrollment procedures (§ 1311[d][4][A]–[E]). States are also tasked with screening individuals for eligibility for public assistance programs, such as Medicaid and CHIP (Children’s Health Insurance Program), and they must enroll individuals if appropriate (§ 1311[d][4][F]). Moreover, states must provide an electronic calculator for potential enrollees in order to evaluate the costs of enrollment and assess whether they are exempt from the individual mandate requirement (§ 1311[d][4][G]–[H]). All transactions must be secure and maintain the privacy of individuals (§ 1413). Finally, states must develop a navigator program to assist individuals with plan selection and enrollment (§§ 1311[d][4][K], 1311[i]).

Role of the Secretary of Health and Human Services

The HHS secretary is assigned a variety of crucial responsibilities in the establishment and operation of the exchanges. First, the secretary is granted significant discretion in the awarding of grants to the states (§ 1311[a]). At the same time, the secretary is also responsible for developing certification criteria for qualified health plans eligible for the exchanges (§ 1311[c]). Qualification criteria address issues regarding marketing, provider choice, provider networks, quality of care measurements, and enrollment (§ 1311[c][1]). The secretary also is charged with the development of a rating system that takes into account quality of care and price (§ 1311[c][3]), as well as an enrollee satisfaction survey (§ 1311[c][4]).² Moreover, the secretary is to support states in developing and maintaining Internet portals (§ 1311[c][5]). Finally, the secretary, in cooperation with the states, is tasked with monitoring premium increases inside as well as outside the exchanges beginning in 2014 (§ 2794[b]).

Benefits and Enrollment for Individuals and Small Businesses

Coverage will be provided at five actuarial levels: bronze, silver, gold, platinum, and catastrophic coverage (§ 1302). States are

limited to offering only QHPs in their exchanges (§ 1311[d][2]). QHPs, as already noted, are those that meet the minimum requirements established by the HHS secretary and the ACA (§§ 1301, 1311). Among other requirements, participating health plans must provide justification for premium increases before they take effect (§ 1311[e]), and they must offer at least one silver-level and one gold-level plan (§ 1301). Insurers must charge the same premium rates for plans inside and outside the exchange, which should limit adverse selection (§ 1301). Benefits must include a variety of services, including ambulatory patient services, prescription drugs, emergency services, maternity and newborn care, hospitalization, mental health and substance use disorder services, and preventive and wellness services (§ 1302).

As envisioned under the ACA, individuals below 133 percent of the federal poverty line will be eligible for state Medicaid programs (§ 2001), while those above 100 percent and below 400 percent are eligible for sliding-scale premiums capped at between 2 percent and 9.5 percent of income.³ The U.S. Supreme Court’s 2012 decision⁴ provides states the opportunity to reject the Medicaid expansion, creating significant uncertainty about coverage for individuals above the Medicaid threshold but below the starting level for federal subsidies. We note that the overlap in eligibility was originally intended to allow for the smooth transition of beneficiaries between exchanges and state Medicaid programs. However, in response to the reluctance of a number of Republican governors to expand Medicaid, this may offer the Obama administration an additional opportunity to expand coverage despite the opposition. Even before the ruling, concerns about affordability were prominent in light of the coverage expansion without strong cost containment. To alleviate some concerns about affordability, the federal government will spend \$1 trillion in subsidies (\$5,510 per beneficiary) by 2022, although estimates have been persistently raised (Merline 2013). Premiums may not be based on health status rating; age rating is limited to a 3:1 ratio,⁵ and tobacco use rating is limited to a 1.5:1 ratio (§ 2701). Low-wage small businesses can receive tax credits covering up to 50 percent of the employer’s share of premiums (§ 45R). States may exceed the number and types of benefits required by the ACA but assume all costs for qualified individuals (§ 1311[d][3]). Members of Congress and their staff may enroll in health insurance solely through exchanges (§ 1312[d][D]). Finally, access through exchanges is limited to U.S. citizens and lawful residents (§ 1312[f]).

Overview of Exchange Implementation

Following a long tradition in American social welfare policy, the ACA relies extensively on the cooperation of states for implementation (see Haeder 2012). Although this federal approach offers significant potential for local adaptations, it also creates a number of potential roadblocks. These roadblocks may be the result of deliberate state opposition or a sheer lack of capacity in resource-strapped states suffering economic woes. As the preceding discussion should have made clear, insurance exchanges are complex institutions. States face time pressures in making important political decisions, such as the choice of governance arrangements for the exchanges, as well as more technical decisions relevant to the expanded state regulatory role in

Roadblocks may be the result of deliberate state opposition or a sheer lack of capacity in resource-strapped states suffering economic woes.

insurance markets. State responses have varied widely, ranging from enthusiastic support to uncompromising opposition, at least rhetorically, and in many cases joining in the lawsuit ultimately resolved by the Supreme Court. Table 1 displays two important responses to the ACA: Did the state join or file a lawsuit against the ACA? And did the state establish an insurance exchange? We would expect most states to either support the ACA fully—that is, not to file a lawsuit and to implement an exchange—or completely oppose it by participating in the lawsuit and not implementing an exchange. Not surprisingly, the majority of states fall in the northeastern and southwestern quadrants that display these consistent behaviors. Yet a significant number, about one-third of states, do not. Naturally, this raises interesting questions for further investigation.

For purposes of analysis, table 1 presents implementation progress as a dichotomy. As our subsequent discussion makes clear, those states that have not yet formally implemented exchanges fall into several categories, ranging from inadvertent delay to purposeful delay to outright refusal. Also note that it is possible that a state may have established an exchange that is not in full compliance with the ACA.

In terms of formal implementation, 13 states have enacted legislation or issued executive orders to establish exchanges while refraining from joining the legal challenge against the ACA.⁶ California under Republican governor Arnold Schwarzenegger was the first state to establish an exchange under the ACA in 2010; Rhode Island did so under independent governor Lincoln Chafee in late 2011. However, the other states are controlled by Democrat governors.⁷ All exchanges except those in Kentucky, New York, and Rhode Island were established by legislative action, generally with some Republican support but also

In the three states with functioning exchanges, the enabling legislation is relatively short and leaves many details of implementation unspecified. These states received grants in excess of \$289 million.

substantial opposition. The Rhode Island exchange was established by executive order after the legislature could not agree on compromise legislation. Democrat governors Andrew Cuomo of New York and Steve Beshear of Kentucky issued executive orders establishing exchanges in mid-April 2012 and after the Supreme Court decision, respectively. All of these states are moving forward swiftly and were awarded more than \$2.6 billion in grant funding. Interestingly, Vermont intends to use the exchange as a stepping stone toward a single-payer system, while West Virginia has since moved away from establishing a state-based exchange. While most exchanges are reasonably well defined, all must nonetheless address a variety of issues during implementation.

Four states established exchanges while also joining the lawsuit against the ACA.⁸ In Colorado and Washington, Republican attorney generals joined the ACA lawsuit over the objections of their governors, whereas in Nevada, a Republican governor joined the lawsuit independently of the attorney general. Indiana appears to be an anomaly in this category, as the offices of governor and attorney general as well as both chambers of the legislature are controlled by Republicans. However, the exchange is virtually nonfunctional,

and newly elected Republican governor Mike Pence has rejected the idea of a state exchange. Exchanges were established by legislative action with unified Democrat control in both Nevada and Washington. In the three states with functioning exchanges, the enabling legislation is relatively short and leaves many details of implementation unspecified. These states received grants in excess of \$289 million.

Including Utah, 25 states⁹ have failed to establish exchanges while joining the ACA lawsuit.¹⁰ In all states, the governor is a Republican, and generally the attorney general is Republican as well. In states with Democrat attorney generals, the lawsuit was joined by the governor directly after a change in the governor's party in the November 2010 elections. Except in Iowa, Republican majorities control both chambers of the legislature.¹¹ Tea Party opposition appears to have played a particularly prominent role in delaying implementation. Nonetheless, 10 of these states accepted more than \$400 million in grant funding.

Finally, nine states did not join the ACA lawsuit yet so far have failed to establish exchanges.¹² With a few exceptions, these states have Democrat governors and attorney generals. In New Jersey, legislation was vetoed by Republican Governor Chris Christie despite strong public support in the state (Livio 2012). Legislatures in these states are often split yet lean slightly more Republican than Democrat. Entities such as task forces and commissions to study or pursue the planning for exchanges have been established in virtually all of the states. In a few of these states, Tea Party activism appears to have slowed or derailed implementation efforts. Counting West Virginia, these states received almost \$220 million in grant funding.

Themes in Implementing Insurance Exchanges

Since passage of the ACA, we have intently followed the developments across the states in implementing insurance exchanges. Our research included, among other components, a diligent review of

Table 1 Legal Position and Implementation Progress

	Exchange Established	Exchange Not Established	
Joined lawsuit	Colorado	Alabama	Nebraska
	Indiana ^a	Alaska	North Dakota
	Nevada	Arizona	Ohio
	Washington	Florida	Oklahoma
		Georgia	Pennsylvania
		Idaho	South Carolina
		Iowa	South Dakota
		Kansas	Texas
		Louisiana	Utah
		Maine	Virginia
		Michigan	Wisconsin
		Mississippi	Wyoming
	Did not join lawsuit	California	Arkansas
Connecticut		Delaware	North Carolina
Hawaii		Illinois	Tennessee
Kentucky		Minnesota	
Maryland		Missouri	
Massachusetts		Montana	
New York		New Hampshire	
Oregon		New Jersey	
Rhode Island			
Vermont			
West Virginia ^b			

Source: Authors, various sources, November 2012.

^a Indiana's exchange, while established, is currently nonfunctional.

^b West Virginia has since opted for a partnership exchange.

newspaper articles, foundation reports, newsletters, press releases, academic articles and books, Web sites, executive orders, statutes, and conference presentations. A variety of themes emerged from these sources.

Theme 1: Health Reform, Finally!

A variety of Democrat-leaning states moved quickly after enactment of the ACA and established exchanges between December 2010 and July 2011. In the cases of Colorado and Oregon, exchanges required Republican support to pass in the legislature, and in California, a Republican governor wholeheartedly came out in support. These states generally have been eager to reform their insurance markets and, despite some Republican opposition, were able to move forward. New York, on the other hand, was not able to overcome a divided legislature and required an executive order to do so.

The implementation was perhaps most tense in Colorado, where Democrat governor John Hickenlooper signed legislation establishing the Colorado Health Benefit Exchange as a quasi-governmental organization. Colorado had debated insurance exchanges well before the ACA. The legislation passed despite strong Tea Party opposition (Malone 2011). Nonetheless, the legislation was bipartisan, with passage in the Republican House and Democrat Senate. But negotiations prior to the compromise were tense and intensive; no Republican senator voted for the bill. However, the legislation had overwhelming support from the business community (Malone 2011) and the health industry (Wyatt 2011).

In Rhode Island, Governor Chafee signed an executive order to establish the Rhode Island Health Benefit Exchange after the legislature failed to agree on enabling legislation. Legislation passed overwhelmingly in the Senate yet failed in the lower chamber. The Senate legislation severely restricted access to abortion services. Without legislation, the exchange was necessarily created as an agency within an executive department. Rhode Island is also a member of the consortium of New England states that received a federal Early Innovator Grant and the first state to receive a Level Two grant.

Theme 2: Health Reform, Finally?

Not all states with strong Democrat presences have been equally successful. In Illinois, Democrat governor Pat Quinn signed legislation declaring the state's intention to move forward with the establishment of an insurance exchange. Governor Quinn also formed a task force on health reform that made a wide variety of recommendations, and the Illinois legislature set up a bipartisan study committee to consider the insurance exchange. However, in May 2012, the legislature officially refused to take any action before the U.S. Supreme Court verdict as Democrat leaders sought bipartisan support. Work on the exchange has been led by the governor's office, the Department of Insurance, and the Department of Healthcare and Family Services, which created a study group and sought stakeholder participation. Republicans in the legislature have voiced their opposition despite insurers and business groups appearing to favor a state exchange (Olsen 2011).

Under Democrat governor Mike Beebe and the state insurance commissioner Jay Bradford, Arkansas undertook extensive efforts to initiate the creation of a health insurance exchange, including

deliberation with various stakeholder groups and the Arkansas Health Benefits Exchange Steering Committee. Legislation to establish a state insurance exchange was introduced in the Democrat-controlled legislature but failed. In the face of Arkansas's supermajority requirements and extensive legislative opposition from the Republican minority, Arkansas only applied for a planning grant, and Governor Beebe distanced himself from any efforts to establish an exchange (Tolbert 2011). However, a variety of stakeholders, including the Arkansas Hospital Association, Blue Cross Blue Shield, and the Independent Insurance Agents of Arkansas, strongly supported the creation of a state-based exchange. Nonetheless, the state is planning for a partnership exchange.

Theme 3: To Implement or Not to Implement—The Republican Dilemma

After passage of the ACA, Republicans outside Washington, D.C., found themselves confronted with an interesting dilemma: either support the implementation of the ACA and develop local, conservative solutions or come out vocally against it and refuse to cooperate at all costs. Initially, there appeared to be no clear strategic choice, as both responses occurred. A variety of governors embraced the opportunity to develop a state exchange and argued that a state solution would trump anything that the federal government could do by allowing for efficient solutions appropriate for each state. For example, in Nevada, Republican governor Brian Sandoval signed legislation establishing the Silver State Health Insurance Exchange as a quasi-governmental organization. The legislation passed unanimously in both chambers and had the support of the business community (Doughman 2011). Ever since, Nevada has been at the forefront of exchange development, as Governor Sandoval has stuck to his initial argument favoring a state-based solution (Bartolone 2012).

Another group of governors, including Republicans Susana Martinez of New Mexico and Rick Snyder of Michigan, have also expressed support for state-based solutions, albeit in a more reserved fashion. In New Mexico, Martinez first vetoed exchange legislation but then appointed a new director of the Office of Health Care Reform and supported grant applications. The grant application outlined the proposed structure of the exchange as part of the New Mexico Health Insurance Alliance, an existing entity that provides access to insurance for small employer groups and qualifying individuals. In Michigan, with Governor Snyder's support, legislation was introduced and passed in the Senate. Tea Party activists were vocal opponents of the legislation (Brush 2011), and the bill ultimately failed. Finally, in Tennessee, Republican governor Bill Haslam initially seemed to favor a state-based solution as well, but he has since reversed course.

Exchange activities in Mississippi have differed markedly from other states. Republican insurance commissioner Mike Chaney established an exchange called One, Mississippi, regulated by the Insurance Department without further legislation as part of the Mississippi Comprehensive Health Insurance Risk Pool Association. The language establishing the risk pool offered the insurance commissioner a convenient opportunity to pursue the establishment of an exchange without explicit legislation. Former Republican governor Haley Barbour has been supportive of the exchange efforts and, together with Commissioner Chaney, has emphasized the benefits for the state. The legislature also created a Health Insurance Exchange Study

Committee, but the House and the Senate exchange bills could not be merged in conference committee, as one created the exchange as a state entity, while the other opted for nonprofit status. Both bills passed their respective chambers with strong support. Chaney ended up filing the blueprint with the HHS, triggering a prolonged and, at times, comic dispute with Republican governor Phil Bryant. However, the HHS ultimately denied Chaney's blueprint over concerns about interdepartmental cooperation.

The implementation trajectory has been strikingly different in other Republican-controlled states. In Oklahoma, Governor Mary Fallin and Republican leaders in both legislative chambers initially agreed on a proposal to create a state-based exchange. Governor Fallin even enthusiastically accepted an Early Innovator Grant of \$54.6 million, and exchange legislation was introduced and passed the Oklahoma House. Similarly, Kansas was moving along swiftly with its plan to develop a state-based exchange and also received an Early Innovator Grant for \$31.5 million. Finally, in Georgia, Governor Nathan Deal initially supported a state-based exchange and passage of legislation seemed imminent. However, confronted with strong Tea Party opposition, the governor waived and altered his stance. Interestingly, all three governors had recently left Congress to run for governor.

The fortunes of state-based exchanges underwent cataclysmic changes as Tea Party opposition swept conservative states and exerted a particularly strong influence on members of state legislatures, vocally raising concerns about accepting any federal money or engaging in activities that could be interpreted as any form of cooperation with the Obama administration. States overwhelmingly passed constitutional amendments and statutory restrictions in opposition to the ACA's individual and employer mandates and, led by Georgia, began efforts to create interstate compacts. Facing intense criticism and personal attacks, all three governors made about-turns. Both Governor Fallin and Governor Sam Brownback of Kansas returned their states' Early Innovator Grants and other federal funds. Apparently, Fallin had been the subject of massive pressure from a conservative think tank, the Goldwater Institute (Campfield 2012). In addition, states enacted strict abortion coverage restrictions should exchanges be established. Nonetheless, all three governors established executive entities to study state options.

Finally, two states, Louisiana and Florida, have steadfastly refused to comply with the ACA requirements for the establishment of insurance exchanges. Both states are under solid Republican control. Although these states accepted almost \$200 million in ACA-related grants, Louisiana has been one of the most ardent opponents of health insurance exchanges, not only returning its planning grant but also officially refusing to create a state exchange in March 2011. Moreover, it was one of the initial 13 states that filed a lawsuit against the ACA. Louisiana attorney general James Caldwell was the only Democrat to join the lawsuit, although he later switched party affiliations to become a Republican. The state also limited abortion coverage in any future exchange. Nonetheless, the state passed legislation to increase the age limit for dependent children coverage to 26 and barred insurance companies from denying coverage

because of preexisting conditions. However, against the wishes of Republican governor Bobby Jindal, the Senate introduced legislation to establish an exchange, which was ultimately rejected.

Florida has been the most vocal state in opposition to the ACA and took the lead in the lawsuit filed by 13 states the day after its enactment. Republican governor Rick Scott, a former Columbia/HCA executive, has persistently refused to implement any component of the ACA. Nonetheless, the state enacted restrictive abortion provisions for health plans participating in any future exchange. Florida also returned its planning grant and, like Louisiana, refused to create a state-based high-risk insurance pool as part of the ACA. However, Florida is moving forward with its Florida Health Choices program, which is similar to the Utah insurance exchange (Lopez 2011). In addition, legislation adopted after the ACA was upheld by the Supreme Court allows the state to establish an exchange.

Theme 4: Caught in the Middle—The Influence of Outside Groups on Republicans

As described earlier, Tea Party opposition has been rampant, especially in conservative Southern states. Tea Party activism has been particularly effective at directly influencing lawmakers, who put tremendous pressure on governors to follow suit. Unquestionably, Tea Party activism also helped sweep many governors and lawmakers into power in the 2010 elections. Perhaps more surprising than Tea Party activism is the open, vocal, and persistent opposition of think tanks such as the Cato Institute and the Heritage Foundation. As numerous authors have shown, important parts of the ACA were advocated by analysts in these organizations and modeled on reforms implemented in Massachusetts under Governor Mitt Romney (Hacker 2010; McDonough 2011; Starr 2011). Writing after the enactment of the Massachusetts reforms, Edmund Haislmaier (2006), a visiting research fellow at the Heritage Foundation, argued that exchanges provide “a health system with all the familiar comforts of existing employer group coverage, but with the added benefits of portability, choice, and consumer control. Those are huge positives.” Nonetheless, these think tanks have provided arguments and encouragement for opposition in the states by offering testimony, position papers, and legal opinions.

If anything, the opposition has only hardened since the Supreme Court verdict and presidential election, and the tone has gotten rougher. For example, New Jersey governor Christie, long a favorite of conservative groups across the country, has seen himself confronted with thinly veiled threats from the Koch brothers and Americans for Prosperity (Knickerbocker 2012). Other groups and media organizations such as the blog *RedState* have made direct threats against Republican governors and future presidential candidates should they move to implement exchanges (Erickson 2012). Finally, it appears that the American Legislative Exchange Council has played a significant role in encouraging states to resist the creation of state-based exchanges (Kennedy 2012).

The opposition of social conservatives such as the Tea Party puts Republicans in an interesting situation, as their natural constituencies—trade associations, business groups, and insurance

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companies—have been openly campaigning for state exchanges in virtually every state. Proponents of state exchanges include the traditional Republican spectrum, from the National Federation of Independent Business and chambers of commerce to hospital associations and Blue Cross Blue Shield associations. The stakes are only getting higher with the uncertain future of the Medicaid expansion and the contemporaneous phasing out of disproportionate-share hospital payments. In view of these conflicting constituencies and with literally billions of dollars in question for the hospital and insurance industry, it remains to be seen how Republicans will move forward.

Theme 5: Anything Is Progress—Federal Government Flexibility

The ACA shares a variety of characteristics with earlier federal health reforms, particularly the Health Insurance Portability and Accountability Act of 1996, which also relied extensively on state cooperation yet authorized federal enforcement in case of non-compliance (Ladenheim 1997; Pollitz et al. 2000). In the face of widespread opposition, the federal government has moved forward swiftly and creatively in preparing for the federal fallback option. For example, it contracted with CGI Federal, Inc., to build the federal exchange. Moreover, the HHS has hired the founding director of the Massachusetts health exchange as an advisor and awarded a contract to Quality Software Services to create the Federal Data Services Hub, pulling together information from various federal agencies (Appleby 2011). The merging of data from the U.S. Departments of Homeland Security, Treasury, Justice, and Health and Human Services and the Social Security Administration, and securely integrating and sharing those data with the states, makes this effort potentially one of the biggest IT projects in history. Finally, the federal government has provided large sums of money for IT upgrades for state Medicaid programs.

Nonetheless, federal activities have run into a variety of problems. While there are essentially no limits on funding for state exchanges, the ACA contains no specific funding to set up a federal exchange. Moreover, the ACA limits appropriations for federal administrative expenditures to \$1 billion. In addition, there have been important turnovers at the HHS and in the Office of Insurance Exchanges. Federal exchanges could run into problems because they lack regulatory authority over health plans outside of the exchanges and over Medicaid programs. Medicaid in particular is an essential component of the ACA for coverage expansion. Hence, it is not surprising that the Obama administration has been as accommodating as possible to state efforts. Various actions illustrate this point.

In December 2011, the HHS released long-awaited guidance for the essential benefit package. Against common expectations, the HHS deferred authority to individual states to determine unique benefit packages at least until 2016. Hence, as with current state Medicaid programs, there will be no single, uniform essential benefit package across the country. Each state can choose as its benchmark (1) one of the three largest small-group plans in the state, (2) one of the three largest health plans for state employees, (3) one of the three largest national health insurance options for federal

employees, or (4) the largest health maintenance organization operating in the state's commercial insurance market. If none is selected, then the default is the largest small-group plan in the state.

In addition, the Obama administration has created the partnerships option for exchanges, which was not originally envisioned under the ACA, and has provided states with the opportunity to take over exchanges initially created by the federal government. Moreover, states without fully functioning exchanges can become “conditionally” certified in 2013. Grant deadlines and amounts have also been highly flexible. Moreover, certification deadlines have been extended repeatedly, and it appears more than likely that the HHS will accept state applications on a rolling basis. Finally, the HHS seems to at least be considering Utah's proposal to continue its existing exchange, Avenue H, for small businesses and to abdicate responsibility for the individual exchange to the HHS.

Public Administration in the Face of Adverse Politics

Following the implementation progress across the states, we noticed the central role that an often obscure group of administrators have played: insurance commissioners. Yet despite their pivotal role in the health care market, insurance commissioners have not been the focus of much scholarly attention (except Balla 2001; Meier 1988). States vary widely in terms of selection and capacities of their offices of commissioner of insurance, which regulate insurance and generally play a lead role in designing the exchanges. Eleven insurance commissioners are elected directly, while most of the rest are appointed by the governor. Appointments by governors require legislative confirmation in a majority of states. Moreover, insurance departments differ significantly in terms of staff and budgets, from a low in Wyoming with 27 full-time equivalents (FTE) and South Dakota with \$1.8 million to California with more than 1,700 FTE and \$153 million in 2010. Adjusted by state population, the respective numbers differ from 14.5 FTE to 220 FTE per million residents in Arizona and West Virginia, respectively, and \$1.4 million to \$11.1 million per million residents in Indiana and Vermont, respectively.

In virtually every state, insurance commissioners and their staffs have played critical roles in preparation and planning for insurance exchanges. An extensive analysis, including newspaper articles, federal grant applications, and insurance department Web sites, shows that their efforts have included rhetorical leadership, conducting stakeholder meetings, general research, and acting as liaisons with the HHS, among many others. Insurance commissioners have also taken leadership roles in at least 44 of the 49 task forces or commissions established by governors to support state decision

Many insurance commissioners have been actively lobbying for their states to adopt insurance exchanges instead of relying on the federal fallback option.

making in the implementation of the ACA in general and exchanges in particular. Some have also created an interstate workgroup on insurance exchanges. Moreover, insurance commissioners serve on the boards of directors of insurance exchanges in at least 13 states. Many insurance commissioners have been actively lobbying for their states to adopt insurance exchanges instead of relying on the

federal fallback option. Insurance commissioners Sandy Praeger in Kansas and Monica Lindeen in Montana, like many others, have done so despite strong opposition in their states from governors and

legislators. West Virginia even established its exchange within the insurance department. A review of insurance department Web sites also showed that at least 45 provided easily accessible information about the ACA in general and implementation activities in the state. Finally, as previously noted, Mississippi insurance commissioner Chaney attempted to establish an exchange regulated by the insurance department.

The critical role of insurance commissioners is also evident when looking at the state agencies receiving federal exchange grants. The insurance department was the recipient of 22 of the 46 planning grants and 23 of the 57 Level One grants. Insurance commissioners have been particularly important in states that joined the lawsuit against the ACA and have failed to establish an exchange. Out of 19 states that received planning grant funding, 11 used their insurance departments as administrators, whereas out of the 11 states that received Level One grants, six used their insurance departments as administrators (14 grants total). A similar picture emerges for the states that did not join the lawsuit yet have failed to create a state-based exchange. Here, insurance departments were the recipient of eight planning grants (out of 10) and nine Level One grants (out of 14). The other states generally utilize their health or welfare departments as recipients.

Only a small number of insurance commissioners have been openly opposed to the implementation of state-based exchanges. Some of them, such as Mary Taylor, who is also Ohio's lieutenant governor, have utilized their position as a podium to express their general opposition to the ACA. Taylor returned federal grant funding to support implementation of the ACA, including the planning grant. North Dakota's insurance commissioner, Adam Hamm, also in opposition to the ACA, has proposed abdicating all responsibility to the federal government and, if necessary, eventually taking over a federal exchange. Finally, South Carolina's insurance commissioner was forced to resign in expectation of a federal investigation of mishandling grant funding for insurance exchanges.

A Quantitative Assessment of Exchange Implementation Activities

Does the administrative capacity of the office of insurance commissioner affect the probability of timely establishment of insurance exchanges? To answer this question, we estimate a simple logistic regression model in which the dependent variable is whether or not the state had established an exchange prior to the presidential election in November 2012. The cutoff date seems reasonable, as, at the time, the fate of the ACA was surrounded by considerable uncertainty. As the number of observations is relatively small, we include only five explanatory variables.

First, as an indicator of the position of the executive branch of the state with respect to the ACA, we include the variable *ACA plaintiff*, which takes a value of 1 if the state joined the suit against the ACA and 0 otherwise. Most obviously, we expect a negative coefficient—all other things being equal, states that joined the lawsuit will be less likely to have established exchanges. Second, the *number of mandates* counts the health insurance mandates adopted

by the state.¹³ This variable reflects both the past propensity of the state to regulate health insurance as well as the accumulated experience of the office of the insurance commissioner in implementing the regulation. It has a mean of 42.5 and a standard deviation of 12.9. We expect this variable to have a positive coefficient. Third, as a direct measure of the capacity of the office of the insurance commissioner, we include the *budget of the office in millions of dollar per million people in the state*.¹⁴ It has a mean of 4.7 and a standard deviation of 2.4. Various previous works (Berry 1984; Gormley 1983; Meier 1988; Sapat 2004) addressing bureaucratic influences on regulation, some of which directly addressed the role of insurance commissioners, generally used staff or budget size as a measure of capacity and professionalism. We believe that budgets are more appropriate in our case because insurance departments often rely on contracted employees and consultants whose funding is included in department budgets. We expect this variable to have a positive coefficient. Fourth, we include the *Herfindahl-Hirschman Index (HHI)*,¹⁵ measured in thousands, to control for the concentration in the state's health insurance market. It has a mean of 4.0 and a standard deviation of 1.6. We hypothesize that the more concentrated the market, the less political pressure the dominant firms will apply in support of the exchanges because they enable insurers with smaller market shares to compete more effectively. Finally, we include an indicator variable for *whether or not an insurance commissioner is elected*. We have no clear hypothesis about the direction of the effect of insurance commissioner election.

Model 1 in table 2 summarizes the results of the logistic regression.¹⁶ Note that all of the coefficients (and hence the marginal effects) have the predicted signs. Using one-tailed tests, three of the variables are statistically significant, whereas HHI barely missed significance at conventional levels. Whether an insurance commissioner is elected has no determinable effect. The fourth column of the table provides an indication of the substantive importance of the marginal effects of the variables, holding the other variables at their mean or modal value. So, for example, a state that joined the suit is 38 percentage points less likely to establish an exchange. For continuous variables, we assessed the effects of one standard deviation below

Does the administrative capacity of the office of insurance commissioner affect the probability of timely establishment of insurance exchanges?

the mean to one standard deviation above it. The effect amounts to an additional 21 percentage points for mandates, an additional 14 percentage points for agency budgets, and a reduction by 21 percentage points for HHI, respectively.

We interpret the positive marginal impacts of the number of mandates and the per capita budgets of insurance commissioners' offices as consistent with the argument that this particular form of administrative capacity contributes to timely exchange establishment.

As an alternative specification that assesses the role of the partisan control of the state government, we reestimated the model including indicator variables for whether a *governor was a Republican* and *whether both chambers of the legislature were controlled by Democrats*. We expect the former to have a negative influence and the latter to have a positive influence. We also excluded the variable *ACA plaintiff*. Estimation results for model 2 are also presented in table 2. As

Table 2 Factors Affecting Probability of Timely Exchange Establishment (logistic regression)

	Model 1	Percentage Point Change (all other variables at mean or mode)		Model 2	Percentage Point Change (all other variables at mean or mode)		
		No to Yes			Dem Gov.	Rep. Gov.	
ACA plaintiff	-2.608*** (0.988)		-38				
Number of mandates	0.110*** (0.0425)	± 1 S.D	+21	0.168** (0.0810)	± 1 S.D	+75	+2
Budget per million persons	0.429** (0.212)	± 1 S.D	+14	0.613 (0.404)	± 1 S.D	+34	+1
HHI in thousands	-0.575 (0.364)	± 1 S.D	-21	-0.897 (0.590)	± 1 S.D	-55	-1
Republican governor				-5.202** (2.208)	Change in gov. party	-32	+32
Unified Democrat legislature				4.340** (2.110)	Other to unified Dem.	+65	+16
Elected insurance commissioner	-0.719 (1.075)	Appointed to Elected	-3	-4.838* (2.805)	Appointed to elected	-32	-0.2
Constant	-4.467* (2.415)			-2.005 (4.524)			
N	50			50			
McFadden's R ²	0.41			0.73			
Sensitivity	64.3			92.9			
Specificity	94.4			87.2			
χ ²	24.21***			42.97***			
Log-likelihood	-17.44			-8.161			

Standard errors in parentheses. *** $p < .01$; ** $p < .05$; * $p < .1$

in the first model, the number of mandates is highly significant and positive. However, the budget variable and again HHI just barely miss statistical significance at conventional levels. Indicators for Republican governors and unified Democrat legislature are highly significant both statistically and substantively. Interestingly, whether an insurance commissioner is elected is also highly negatively significant. We again provide an indication of the substantive importance of the marginal effects of the variables, holding the other variables at their mean or modal value. However, we estimate the effects separately for Republican and Democrat governors. For Republican governors, only changes to a unified Democrat legislature are substantively significant. The results are markedly different for Democrat governors. For unified Democrat governments, the effect increases by 65 percentage points. The marginal effect of comparing a state that has a per capita budget one standard deviation below the mean to one standard deviation above is 34 percentage points, whereas the effect is 55 percentage points for HHI. If the insurance commissioner is elected, the probability is reduced by 32 percentage points.

In summary, both the political stance of the state, as indicated by participation in the lawsuit against the ACA and the political configuration of the state government, explain much of the variation in implementation progress of the exchanges. After taking account of these political factors, administrative capacity as indicated by a state's experience with insurance mandates appears to increase implementation progress. Although less robust, so, too, does administrative capacity as measured by the per capita budgets of state insurance offices. Although some caution is needed in light of the small number of observations, it appears that, consistent with our qualitative analysis, both politics and administrative capacity make a difference.

Shhh! Don't Tell Anyone!

As the analysis to this point has made clear, a majority of states have not made adequate progress toward the implementation of viable exchanges. However, a closer look reveals interesting findings. Almost all states have made some progress in preparing for the establishment of health insurance exchanges, although perhaps in less visible ways. As described earlier, insurance departments have been important in furthering implementation of health insurance exchanges by providing leadership, expertise, and rationality. In short, in many cases, the department of insurance has been a hub for planning. However, a variety of other developments also provide evidence that a majority of states may establish exchanges given the

Almost all states have made some progress in preparing for the establishment of health insurance exchanges, although perhaps in less visible ways.

reelection of President Obama. Some of the more reluctant states participated in a National Governors Association retreat addressing technical components of exchange implementation (Manos 2011). In addition, many of the same states have made extensive use of foundation funding, for example, through the Robert Wood Johnson Foundation, particularly for technical expertise (Weaver 2011). Even the recalcitrant Florida has established a Utah-like exchange that offers the potential to come into compliance with the ACA, particularly considering the Obama administration's leniency. In addition, even opposing governors joined in a letter to HHS secretary Kathleen Sebelius requesting more support from the federal government.

Despite vocal opposition, governors and legislators have not been inactive. In various states, multiple task forces have been created. As noted already, 49 governors created entities tasked with studying state options for health insurance exchanges. We note that in most cases, these entities ultimately recommended implementation of state exchanges. In addition, legislatures created at least another

16 committees to address implementation of the ACA. Moreover, legislation to establish exchanges was introduced in at least 44 states. Abortion restrictions were enacted in at least 13 states, failed in at least six states, and are pending in at least eight states. In at least six states without an exchange currently in place, legislation passed in at least one chamber.

As with the diffusion of many other innovations among the states, a network of organizations has facilitated the development and sharing of useful information (Hale 2011). Organizations such as the National Association of Insurance Commissioners and the National Conference of State Legislatures have provided repositories for research and allowed for open discussion. Another venue for research and information is staterforum.org, funded by the National Academy for State Health Policy and the Robert Wood Johnson Foundation. Finally, the HHS has been very generous and supportive of state efforts. Ultimately, both governors and legislators have gained extensive knowledge and have abundant information and resources to move forward.

Implementing states have relied extensively on commercial partners. Private consultants including Ceridian, Deloitte Consulting, Mathematica Policy Research, and Leavitt Partners have been crucial in supporting states' efforts, particularly with respect to the development of the IT infrastructure for exchanges. Not surprisingly, a large amount of federal grant funding has been applied to these contracts, as, for example, the California exchange awarded a \$359 million contract to Accenture. Additionally, foundations have provided significant assistance and garnered expertise since the enactment of the ACA and may prove valuable through tools such as Enroll UX 2014, developed under the auspices of the California HealthCare Foundation. Together, foundations and consultants may utilize their acquired knowledge from both public and private exchanges to facilitate conversion and development of exchanges in the future.

One of the major concerns is the lack of advanced electronic eligibility systems in some of the states, which will greatly impede exchange implementation even under the partnership or fully federal models. Exchanges will require the sharing of enormous amounts of information between a multitude of federal and state agencies—including state Medicaid offices, the HHS, and the Internal Revenue Service—and private health plans that may overwhelm outdated state-legacy IT systems. Thus, the most crucial component of health insurance exchange development is the upgrading and merging of IT systems. Despite opposition to the ACA in many states, the HHS has been able to move forward on this issue. States have large incentives to participate because from April 2011 to December 2015, Medicaid provides enhanced 90/10 matching funds for Medicaid eligibility system upgrades. Moreover, enhanced 75 percent matching for ongoing maintenance will continue indefinitely. As of January 2013, 46 states had submitted applications and 41 had begun work (StateHealthFacts.org 2013). Interestingly, included in this list of states are some of the staunchest opponents of ACA implementation, including Kansas, Louisiana, New Hampshire, and Oklahoma.

As a result, many states may be further along in their preparations for health exchanges than is publicly acknowledged.

Outlook for Insurance Exchanges

State, Federal, Partnership, and Private Exchanges

By the extended February 15, 2013, deadline, only 17 states and the District of Columbia had at least rudimentary exchanges in place. Six states have decided to utilize the exchange as an active purchaser, while six have decided on a clearinghouse model. Five have yet to address the issue. Nine exchanges were structured as quasi-governmental entities, while five will be operated directly by the state. Rhode Island is employing a nonprofit because of the limited reach of the executive order. Two states have not made a decision yet. Foundations have provided significant resources and garnered expertise since the enactment of the ACA. Moreover, many, if not most, insurers have continued preparations for the full implementation of the ACA and its insurance exchanges. In a January 2012 survey conducted by IDC Health Insights, 54 percent of health plans indicated that their planned budget increases “were due to investments in health insurance exchange strategies” despite the uncertainty surrounding the Supreme Court ruling at the time (Lewis 2012).

Simultaneously, 26 states have announced that they will rely exclusively on the HHS to establish exchanges. However, several states among these have indicated that they will be involved in the operation of the exchange in one way or another. For example, Ohio and South Dakota announced that they will retain control over health plan management, while Virginia will continue to license and certify health plans. Moreover, a number of states strongly reiterated that they will retain full control over their Medicaid programs. Finally, seven states have expressed their intent to create partnership exchanges with the federal government. Several of these states have also passed legislation, referenda, or even constitutional amendments to limit or prohibit cooperation in the implementation of the ACA.

Ironically, exchange development will resemble a hybrid between the 2010 House-favored national exchange and the Senate-favored state-based exchanges, albeit with much more limited powers for the HHS. It is equally ironic that the most conservative states—those that totally refuse to cooperate on implementation—may end up with substantially more liberal exchanges because of the leadership of the HHS. Surprisingly, it appears as if states relying on FFEs would also be confronted with the more liberal federal abortion restrictions compared to a state exchange. Sadly, the states most reluctant to cooperate with implementation of the ACA are also those whose populations have the largest potential to benefit from the various ACA provisions.

There are concerns about the capacity of the federal and partnership exchanges to serve adequately as the “one-stop shop” for eligibility determination and enrollment envisioned by the ACA. These concerns had HHS officials temporarily contemplating the takeover of Medicaid enrollment in these states, which was quickly rejected (Feder and Millman 2012). It will also be interesting to see whether

Sadly, the states most reluctant to cooperate with implementation of the ACA are also those whose populations have the largest potential to benefit from the various ACA provisions.

states choose to go ahead with the Medicaid expansion and how eligibility issues will be solved in states that do not expand. The HHS has also run into software problems and has been markedly slow in providing regulatory guidance (Appleby 2012). Nonetheless, the HHS has released more than 1,100 pages in notice-and-comment rulemakings and more than 100 pages in guidance documents solely focusing on insurance exchanges. If rulemakings affecting preexisting conditions, plan management, health market reforms, medical loss ratios, and review of insurance rates are included—all of which significantly affect exchange operations—the number of pages reaches into the tens of thousands.

Finally, in an interesting development, private companies have also moved forward in developing health insurance exchanges or expanding their presence in the market (Kramer 2012). These efforts are a response to growing demand from employers for more choices at lower cost. Major participants include WellPoint, Inc., Microsoft, UnitedHealth Group, Highmark, Inc., and Aon Hewitt. These private exchanges provide opportunities for employers to offer defined contributions to their employees and to offer them more choices. Many of the private exchanges expect to compete directly with the state-based and federal exchanges. However, concerns about cream-skimming arise because private exchanges do not provide subsidies and hence might attract healthier individuals, potentially triggering a death spiral in the public exchanges.

Continued Legal Challenges

In addition to the political debate about exchanges, controversy erupted about the wording of the subsidy provision for individuals between 100 percent and 400 percent of the federal poverty line. The debate centers on the question whether tax subsidies can be extended to individuals in federal exchanges, as asserted in an IRS rule. The issue was reinvigorated by Jonathan Adler and Michael Cannon (2013), who also claim that employers will have legal standing to contest the IRS ruling. Without subsidies, federal exchanges are unlikely to function effectively. In combination with many states' refusal to expand Medicaid, this may effectively gut the ACA. At the very least, it may further bifurcate the health care system for poor Americans by exacerbating existing disparities across states that are already present in Medicaid (Pauly and Grannemann 2010). However, most legal scholars remain skeptical about Adler and Cannon's argument (Kenen 2012). Ultimately, this issue will be resolved by the courts, probably after exchanges begin operation. Moreover, Liberty University has filed a challenge against the requirement that would make most businesses with more than 50 workers provide coverage or pay a fine (Norman and Millman 2012). Further, the Pacific Legal Foundation has filed another lawsuit against the individual mandate claiming that it violates the origination clause (Kenen 2012). Currently, all three claims appear to be longshots.

Sicker, Older, and More Diverse: Insurance Exchange Consumers

Exchange consumers may also affect the future development of exchanges. A Kaiser Family Foundation study (2011) projects that exchange enrollees are going to be relatively older, less educated, poorer, and more racially diverse than the general population. Many of the enrollees will also be previously uninsured or will have obtained coverage from high-risk insurance pools. Moreover, many

healthy 19- to 26-year-olds who gained coverage under the ACA through their parents' insurance plans and would otherwise be potential subscribers to an exchange will also be absent from the risk pool. Overall, enrollees will be in worse health than those currently commercially insured. The heterogeneity of risk associated with these new clients may create strong incentives for selection by health plans despite various provisions in the ACA (§ 1341–43) to guard against such behavior. There have been concerns that self-insured employers could creatively attempt to encourage their most expensive employees to drop coverage and utilize the exchange (Monahan and Schwarcz 2011). Larger companies may be particularly interested in shifting part-time workers and retirees into exchanges as early as 2014 (Kramer 2012), though reputational concerns might balance financial considerations (Stawicki 2011). Moreover, the ACA could push relatively small businesses to self-insure to avoid state regulation and higher premiums in the exchanges, leading to potential adverse selection problems in the small business exchanges (Hall 2012) and increasing the financial risk of the small firms that choose to self-insure.

Future Research

The implementation of health insurance exchanges under the ACA and our presentation of this process here raise a number of interesting questions for future research in the fields of public administration and political science.

First, the implementation of the ACA in general and insurance exchanges in particular presents a fascinating opportunity for studying the intricacies of joint state–federal programs. Even with the president's ink dried, conflict over policies continues unabated in a variety of venues. Implementation should not just be an afterthought because policies are not self-implementing (Pressman and Wildavsky 1973). Public administrators are the heart of this process and are bound to be drawn into political conflict. The case of insurance commissioners provides a vivid illustration. Moreover, the ACA and insurance exchanges offer an opportunity to evaluate the sustainability of reform (Patashnik 2008). With Republican efforts unabated, time will tell whether the ACA sufficiently reconfigures the interest group environment, creates new and resistant political structures, and utilizes market forces to ensure survival.

Certainly, the role of organizations that bring political officials together across the country deserves further investigation (Hale 2011). Interesting examples here are the National Association of Insurance Commissioners, National Conference of State Legislators, and American Legislative Exchange Council, which appear to have been significantly involved with the exchange implementation process in varying roles from active opponent to provider of neutral venues for sharing information.

Finally, the ACA required states to make a decision about whether to cooperate or abdicate responsibility for three separate programs: the expansion of high-risk insurance pools in 2010, the implementation of insurance exchanges, and the expansion of Medicaid. Interestingly, some states did not consistently support all three programs, while others either consistently cooperated on all items or none. The internal dynamics of these decisions deserves further research and should highlight the role of interest groups and political actors. It will also be interesting to follow the developments of

insurance exchanges in particular as very powerful interest groups intend to lobby states to convert to state exchanges from federal exchanges (Scott 2013).

Conclusion

The future of ACA implementation is hard to predict, as “some politicians, like Japanese soldiers who hid in the jungle for years after the end of World War II, are determined to battle on” (*USA Today* Editorial Board 2012). Some predict “a guerilla-style of picking and knocking things off” in both Congress and across the states (Norman and Millman 2012). Exchange subsidies seem to be a particularly endangered target (Baker 2012; Norman and Millman 2012). As mentioned previously, the legal future of the ACA as well as the federal government’s capacity to implement the ACA in the face of state opposition remain uncertain. However, concerns about access to abortion; pressure from hospital, insurance, and business groups; and successful implementation in other states may turn the tide. The expertise and commitment of insurance commissioners, perhaps through the National Association of Insurance Commissioners, also provides reason for optimism. Finally, public opinion is strongly in favor of state-based exchanges, as 63 percent of Americans and 81 percent of Republicans prefer that option to a federal approach (Alonso-Zaldivar and Agiesta 2012).

The implementation of health insurance exchanges as part of the ACA offers many lessons for students and practitioners of public administration. First, even obscure, little-researched agencies and officials such as state insurance commissioners and departments can significantly shape policy implementation. As this is the case for an issue as prominent and controversial as the ACA, it is likely to play an important role in many other less salient circumstances as well.

Second, capacity matters. As our quantitative and qualitative analyses show, not all insurance commissioners have been equally successful in participating in the implementation effort. Third, many insurance commissioners are willing to put politics aside and pragmatically focus on responding in the states’ best interests to federal laws when governors and legislators are distracted by political grandstanding. Fourth, with the vast majority of states having to rely on federally facilitated exchanges, state insurance markets may face an interesting dichotomy between federal and state regulations. The role of the insurance commissioners should be of particular interest in this process. Finally, although only a side note in this article, the roles of associations like the National Association of Insurance Commissioners and American Legislative Exchange Council in implementation deserve further attention.

Looking ahead, the importance of exchanges is not limited to the implementation of the ACA. As former Senate majority leader Bill Frist (2012) put it, exchanges are “perhaps the most innovative, market-driven, and ultimately constructive part of the law,” and we should not forget that they were “originally a Republican idea.” Exchanges have the potential to improve the American health care system dramatically. While exchanges are intended to provide coverage to millions of people across the nation under the ACA, they should also be considered steppingstones toward

resolving even more challenging issues. By eliminating market failures such as job lock-in, lack of portability, and information asymmetry, exchanges can potentially provide a viable, transparent, and competitive marketplace for the purchase of insurance for all Americans. Exchanges would allow movement away from the current employer-based system, with its significant shortcomings, and allow for vigorous competition based on quality and price. Moreover, in view of the tremendous budgetary pressures from Medicare and Medicaid, exchanges make voucher and defined contribution programs more plausible alternatives to contain public expenditures while fostering personal responsibility, competition, and consumer choice (Le Grand 2007). Ultimately, well-implemented exchanges can potentially offer solutions to many of the nation’s health care woes that could be embraced by both liberals and conservatives.

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Notes

1. Author’s calculations from a variety of sources, including the Kaiser Family Foundation, HHS, and National Conference of State Legislatures.
2. Recent guidance by the Center for Consumer Information and Insurance Oversight (2012, 11) pushed back quality of care reporting to 2016.
3. Health and Education Reconciliation Act of 2010, § 1001 and ACA § 1401.
4. *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.*, 576 U.S. (2012), 58–59.
5. However, states may choose a lower ratio.
6. California, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, New Mexico, New York, Oregon, Rhode Island, Vermont, and West Virginia.
7. With the exception of Oregon, where the House of Representatives was tied.
8. Colorado, Indiana, Nevada, and Washington.
9. Alabama, Alaska, Arizona, Florida, Georgia, Idaho, Iowa, Indiana, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, Wisconsin, and Wyoming.
10. Virginia filed a separate lawsuit.
11. Nebraska has a unicameral legislature that is technically nonpartisan.
12. Arkansas, Delaware, Illinois, Missouri, Montana, New Hampshire, New Jersey, North Carolina, and Tennessee.
13. Data were obtained from the Council for Affordable Health Insurance.
14. Data were obtained from the annual Insurance Department Resources Report published by the National Association of Insurance Commissioners.
15. Data were obtained from the Kaiser Family Foundation.
16. We also estimated a complementary log-log model with very similar coefficients and effect sizes.

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As our quantitative and qualitative analyses show, not all insurance commissioners have been equally successful in participating in the implementation effort.

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