You Can't Make Me Do It:

State Implementation of Insurance Exchanges

under the Affordable Care Act*

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October 20, 2012

Abstract

The Affordable Care Act (ACA) has been one of the most controversial pieces of legislation to become law in decades. For its implementation, the ACA relies extensively on the cooperation of states, 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 failed to make significant progress in developing their exchanges. However, many state commissioners of insurance have played a constructive role in moving states forward in exchange planning through expertise, leadership, and pragmatism, sometimes despite strong political opposition to the ACA from governors and legislatures.

*This working paper has been prepared for presentation at the Nov. 2012 APPAM Conference in Baltimore, MD.

The Affordable Care Act (ACA) 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 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 (Conlan and Posner 2011; Greer 2011; Morgan and Campbell 2011; Sparer 2011). Although consistent with the longstanding 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 poses the greatest fiscal challenges to 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 must make a number of decisions about the institutional features of their exchanges within specified deadlines. First and foremost among these decisions, states have to decide whether to create their own exchanges or whether to rely on the federal government instead. These decisions will likely have major impacts on how effective the exchanges will be in contributing to the 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 acceptance to legal challenge (for a discussion of the lawsuits see Joondeph 2011). 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 the states have responded, both in terms of general strategies, ranging from full compliance to outright refusal, and specific choices about institutional features. Third, we attempt to assess the relative impacts of political orientation and administrative capacity on the pace of implementation. Fourth, we speculate on the likelihood that the exchanges will ultimately play their intended role. Fifth, we consider the implications of the experience with the exchanges for our understanding of the implications of relying on state governments for the implementation of national policies adopted by the federal government.

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 less publicized but potentially much more important component of the ACA is the requirement for states to 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 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. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers. (U.S. Department of Health and Human Services 2011)

Various forms of insurance exchanges are currently operating or have operated in the past including, most prominently, the Massachusetts Health Connector and the Utah Health Exchange, as well as the Wisconsin State Employee Benefits Program, 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 have suffered from an extreme adverse selection problem and ultimately succumbed to the ensuing "death spiral" (Colliver 2006; Gardiner 2012; Reichard 2009).

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 exceeds federal requirements and was followed by the establishment of exchanges in West Virginia and Maryland. According to the Congressional Budget Office (CBO), exchanges will provide coverage to 9 million individuals in its first year and 23 million

by 2017 (Congressional Budget Office and Staff of the Joint Committee on Taxation 2011). 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 U.S. 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, HHS has disbursed almost $1.2 billion in grant funding to support planning for establishment of exchanges.[1] Finally, the federal government is predicted to subsidize coverage with $345 billion between 2014 and 2019 making subsidies for exchanges the most expensive component of the ACA (Buttgens, Dorn, and Carroll 2011).

Establishment

At the most basic level, a state must decide whether to establish its own exchange or to instead rely on the Secretary of HHS and the federal government to provide one. Under the ACA, state exchanges (*American Health Benefit Exchanges*) must be certified by January 1, 2013 by the Secretary of HHS[2] and established no later than January 1, 2014 to "facilitate[] the purchase of qualified health plans."[3] By the same date, states must also have established a Small Business Health Options Program (*SHOP*) "designed to assist qualified employers [fewer than 100[4]] in the State […] in facilitating the enrollment of their employees in qualified health plans offered in the small group market."[5] However, states may initially limit participation to those employers with fewer than 50 employees.[6] States may combine both functions or utilize separate entities.[7] All members of each program are treated as a single risk-pool unless determined otherwise by the state.[8] By 2017 states may open up exchanges to larger employers as well. In

case a state fails to comply with these requirements, the Secretary of HHS is charged with the establishment and operation of the state exchange.[9]

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, CMS provided states with more options, including various degrees of partnerships with the federal government for components of the exchange such as information technology (IT) systems. States may also take over federally established exchanges after a period of time (Aizenman 2011). Moreover, states without fully functioning exchanges can become "conditionally" certified in 2013. States will also 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

States have been granted significant flexibility in the establishment of their exchanges. First, exchanges can be created as either a governmental agency (either within an existing agency or as a stand-alone entity) or as a nonprofit organization.[10] States may also establish regional exchanges that operate in multiple states (*interstate exchanges*) or within select regions of the respective state (*subsidiary exchanges*)[11] although interestingly no states appear 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.[12] Exchanges must be self-sustaining by January 1, 2015 and may assess user fees to participating health plans or other measures to achieve that goal.[13] States are encouraged to consult with a broader base of

stakeholders in the development and operation of their exchanges.[14] Although exchanges are subject to a variety of financial integrity requirements,[15] the ACA is silent on the specific governance structure states may decide upon 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 also decide whether their exchanges should act as active purchasers[16] or take a more passive role as a mere clearinghouse or marketplace. The American Medical Association (AMA) has pushed against the active purchaser model ("American Medical Association seeks open market-style health insurance exchanges" 2011), though both the AMA and insurance carriers have lobbied for providing states with the greatest latitude possible (Potter 2011).

Exchange Functions

A variety of minimum requirements were 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, 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.[17] States are also tasked with screening individuals for eligibility for public assistance programs, such as Medicaid and CHIP, and they must enroll individuals if appropriate.[18] Moreover, states must provide an electronic calculator for potential enrollees in order to evaluate costs of enrollment and assess whether they are exempt from the individual mandate requirement.[19] All transactions must be secure and

maintain the privacy of individuals.[20] Finally, states must develop a navigator program to assist individuals with plan selection and enrollment.[21]

Role of the Secretary of Health and Human Services

The Secretary of HHS has been assigned a variety of crucial responsibilities in the establishment and operation of the exchanges. First, the Secretary has been granted significant discretion in the awarding of grants to the states.[22] Grant funding for states is expected to amount to about $1.9 billion (Baker 2011a). At the same time, the Secretary is also responsible for developing certification criteria for qualified health plans eligible for the exchanges.[23] Qualification criteria include issues regarding marketing, provider choice, provider networks, quality of care measurements, and enrollment.[24] The Secretary also is charged with the development of a rating system taking into account quality of care and price[25] as well as an enrollee satisfaction survey.[26, 27] Moreover, the Secretary is to support states in developing and maintaining Internet portals.[28] Finally, the Secretary, in cooperation with the states, is tasked with monitoring premium increases inside as well as outside the exchanges beginning in 2014.[29]

Benefits and Enrollment for Individuals and Small Businesses

Coverage will be provided at five actuarial levels: bronze, silver, gold, platinum, and catastrophic coverage.[30] States are limited to offering only Qualified Health Plans (QHP) in their exchanges.[31] Qualified Health Plans, as already noted, are those meeting the minimum requirements as established by the Secretary of HHS and the ACA.[32] Among other requirements, participating health plans must provide justification for premium increases prior to their taking effect[33] and they must offer at least one silver level and one gold level plan.[34] Insurers must charge the same premium rates for health plans in the exchange as well as outside, which should

limit adverse selection.[35] Benefits must include a wide 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.[36]

As envisioned under the ACA, individuals below 133 percent of the federal poverty line (FPL) will be eligible for state Medicaid programs[37] while those above 133 percent and below 400 percent are eligible for sliding-scale premiums capped at between 2 and 9.5 percent of income.[38] However, the recent Supreme Court decision[39] provides states the opportunity to reject the Medicaid expansion, creating significant uncertainty about coverage for individuals above the Medicaid threshold and below the starting level for federal subsidies. Even before the ruling, concerns about affordability were prominent in light of the coverage expansion without strong cost containment (Trapp 2011c, 2011b). To alleviate some concerns about affordability, the federal government will spend $345 billion on premium and cost-sharing subsidies between 2014 and 2019 (Buttgens, Dorn, and Carroll 2011). Controversy erupted about the wording of the subsidy provision for individuals between 133 and 400 percent of FPL (Baker 2011b). The debate centers on the question of 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 the Michael Cannon (2012) 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. However, most legal scholars remain skeptical about Adler and Cannon's argument (Feder 2012a).Ultimately, this issue will probably be resolved by the courts after exchanges begin

operation. Finally, health ratings are prohibited while age rating is limited to a 3:1 ratio[40] and tobacco use rating is limited to a 1.5:1 ratio.[41]

Low-wage small businesses can receive tax credits covering up to 50 percent of the employer's share of premiums.[42] States may exceed the number and types of benefits required by the ACA but assume all costs for qualified individuals.[43] Members of Congress as well as their staff may solely enroll in health insurance through exchanges.[44] Finally, access through exchanges is limited to U.S. citizens and lawful residents.[45]

In view of the intended clientele of the exchanges, it is not surprising that a Kaiser Family Foundation study projects that exchange enrollees are going to be relatively older, less educated, poorer, and more racially diverse than the general population (Henry J. Kaiser Family Foundation 2011). Many of the enrollees will also be previously uninsured or 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 who would otherwise be potential subscribers to an exchange are also excluded 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[46] to guard against such behavior (Weiner et al. 2012). 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). However, reputational concerns might balance financial considerations (Stawicki 2011). Moreover, the ACA could also 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..

In December 2011, HHS released long-awaited guidance for the essential benefit package. Against common expectations, HHS deferred authority to individual states to determine unique benefit packages at least until 2016. This has drawn criticism from patient advocates and praise from state officials (Levey 2012). Hence, as with current state Medicaid programs, there will be no single, uniform essential benefit package across the country. Each state can choose either (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 as a benchmark. If none is selected, then the default is the largest small group plan in the state. Republican leaders have complained to HHS, alleging that Secretary Sebelius failed to meet legal requirements under the ACA to avoid cost-benefit analyses of its regulations ("GOP: HHS Skirted Legal Rules When It Issued Essential Benefits" 2012). The complaint also asserts that the bulletin does not have the force of law.

Federal Exchange and Activity

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 for a potential fee of up to $93.7 million ("CGI Group gets gov't health exchange contract" 2011). The contract was awarded through the Centers for Medicare & Medicaid Services. Moreover, HHS has hired Jon Kingsdale, the founding director of the Massachusetts

health exchange, as an advisor (Feder 2011a) and awarded a $69 million contract to Quality Software Services (QSS) to create the Federal Data Services Hub pulling together information from various federal agencies (Appleby 2011b). Merging data from the departments of Homeland Security, Treasury, Justice, HHS, and the Social Security Administration and securely integrating and sharing the data with the states, makes this potentially one of the biggest IT projects in history. QSS is also participating in upgrading the healthcare.gov website with more information on insurers and the ACA as part of preparations for a federal exchange. Finally, the federal government has provided large sums of money for IT upgrades for state Medicaid programs. These upgrades are generally 90 percent funded by the federal government (Appleby 2011b).

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 for HHS to set up a federal exchange (Feder 2011b). Moreover, the ACA also limits appropriations for federal administrative expenditures to $1 billion, which may prove inadequate. Moreover, Joel Ario, director of the HHS Office of Insurance Exchanges and a former insurance commissioner in two states, resigned in September 2011 (Trapp 2011a). Federal exchanges could run into problems because they completely lack regulatory authority for health plans outside of the exchanges and for Medicaid programs. Medicaid in particular is an essential component of the ACA for coverage expansion. It is also questionable if states will refuse to cooperate or even be outright hostile towards federal intervention.

The Challenge of Complexity: State Responses

As the preceding discussion should make 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 involved in the expanded state regulatory role in insurance markets. State responses have varied widely, ranging from enthusiastic support to uncompromising opposition, at least rhetorically or in many cases joining in the lawsuit ultimately resolved by the Supreme Court. Table 1 displays states' behavior with respect to two important responses to the ACA: Did they join or file a lawsuit against the ACA? And did they establish an insurance exchange? We would expect most states either to support the ACA fully—either not to file a lawsuit and to implement an exchange, or to completely oppose by participating in the lawsuit and not implementing the 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.

(Table 1 about here)

At the same time, closer analysis of the states behaving "as expected" also brings about interesting findings. Almost all states have made some progress in preparing for the establishment of health insurance exchanges, although perhaps in less visible forms (Grogan 2011). Private consultants including Accenture, Ceridian, Deloitte Consulting, Mathematica

Policy Research, Wakely Consulting Group, Leavitt Partners, and Milliman have been crucial in supporting states' efforts, particularly for the development of the IT infrastructure for exchanges. Not surprisingly, a large amount of federal grant funding has been applied to these contracts. The California exchange, for example, awarded a $359 million contract to Accenture. At the same time, the role of conservative think tanks like the Cato Institute, The Heritage Foundation, and the American Enterprise Institute in opposition to state implementation of the ACA should be highlighted. Finally, it appears as if the American Legislative Exchange Council (ALEC) has played a significant role in encouraging states to resist the creation of state-based exchanges (Kennedy 2012). We are now observing the extent to which states have the political will and administrative wherewithal to meet the implementation challenge.

Created Exchange and No Lawsuit

Ten states (California, Connecticut, Hawaii, Maryland, Massachusetts,[47] New York, Oregon, Rhode Island, Vermont, and West Virginia) have enacted legislation or issued executive orders to establish exchanges while refraining from any legal challenge against the ACA. California, under a Republican governor, was the first state to establish an exchange under the ACA and Rhode Island also did so under an independent governor in late 2011. However, other states are controlled by Democrats including the office of governor and attorney general as well as both chambers of the legislature.[48] All exchanges except those in Rhode Island and New York were established by legislative action with generally some Republican support but also substantial opposition. The Rhode Island exchange was established by executive order[49] after the legislature could not agree on compromise legislation. The same occurred in New York where Governor Cuomo issued an executive order[50] establishing the exchange in mid-April. All these

states are moving forward swiftly and were awarded *Level One Establishment Grants*. Rhode Island has also been awarded a long-term *Level Two* grant worth $58.5 million. In four of the cases at least one exchange grant was awarded to the department of insurance. Six states have decided to utilize the exchange as an active purchaser while three have either avoided decisions (West Virginia and New York) or delegated it to the exchange (Maryland). Hawaii, because of its challenging insurance market, has opted for a clearinghouse model. Seven exchanges were structured as quasi-governmental entities while four will be operated directly by the state. Rhode Island is employing a non-profit because of the limited reach of the executive order. Vermont intends to use the exchange as a stepping-stone towards a single-payer system. The enacting documents vary widely in length from a low in West Virginia with about 2,500 words to a high in California (more than 11,000 words) and Vermont (more than 29,000 words).[51] This underlines the varying amount of control legislatures have decided to exert on the implementation process. While most exchanges are reasonably well-defined, all must nonetheless address a variety of implementation issues.

Created Exchange but Joined Lawsuit

Four states established exchanges while also joining the lawsuit against the ACA: Colorado, Indiana, Nevada, and Washington. In Colorado and Washington a Republican attorney general 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, because the governor and the attorney general are Republican and both chambers of the legislature are controlled by Republicans. Exchanges were established by legislative action with unified Democratic control in both Washington and Nevada. In

Colorado the legislation was bipartisan with passage in the Republican House and the Democratic Senate (Goldman 2012; Paulson 2011). However, negotiations prior to the compromise were tense as no Republican Senators voted for the bill. However, the legislation had overwhelming support from the business community (Malone 2011) and the health industry (Wyatt 2011). All exchanges except for Indiana's were established as quasi-governmental entities. In all these states, the enabling legislation is relatively short and leaves many aspects of implementation unspecified. Both Washington and Nevada received Level One Establishment Grants whereas the Colorado application was delayed by disagreements in the legislature. However, Colorado ultimately received $18 million in Level One grants. In none of the states were exchange grants awarded to the department of insurance. However, Washington received a Level Two grant worth $128 million, making it only the second state to do so.

Indiana Governor Mitch Daniels (R), despite being a vocal critic of the ACA (Daniels 2011), quickly moved to establish the Indiana Health Benefit Exchange as a non-profit corporation per executive order in January 2010.[52] However, the executive order is very brief and provides little structure or guidance for the establishment of the exchange. The Governor's action was followed by the introduction of legislation for the same purpose that ultimately failed.[53] Indiana also was one of the first states to apply for and receive a Level One Establishment Grant for $6.9 million. Currently, the Indiana Health Benefit Exchange is actively engaged in moving towards operationalizing the exchange. However, administration officials have continued to express their criticism of the ACA and federal regulation (Wall 2011). Indiana is also the only solidly Republican state that has established at least a rudimentary exchange.

No Exchange Created and No Lawsuit

Twelve states did not join the ACA lawsuit yet have so far failed to establish exchanges: Arkansas, Delaware, Illinois, Kentucky, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, and Tennessee. Generally these states have Democratic governors and attorney generals with the exception of New Jersey, New Mexico, and Tennessee where the executive is not unified. In New Jersey, legislation was vetoed by Governor Christie despite strong public support in the state (Livio 2012). Legislatures in these states are often split yet trend slightly more Republican than Democrat. Entities to either study or pursue the planning for exchanges have been established in virtually all of the states. All states received planning grants and eight of the twelve received Level One Establishment Grants. In eight of the cases at least one exchange grant was awarded to the department of insurance. The other states generally utilize their health or welfare departments as grant recipients. Absent legislation, governors have often utilized the state insurance departments (especially early in the process) or ad hoc entities to move planning forward. Not surprisingly, this centralization of planning activity appears to be particularly prevalent when governors face legislatures controlled by the opposing party. Democratic governors facing Republican legislatures have generally been less vocal about their support for exchanges. In a few cases, Tea Party activism appears to have slowed or derailed implementation efforts.

Two Democratic states stand out in this group. In Illinois, Governor Pat Quinn (D) signed legislation stating the state's intention to move forward with the establishment of an insurance exchange.[54] However, legislation establishing the actual exchange proved controversial.[55] In May 2012 the legislature officially refused to take any action before the Supreme Court verdict as Democrat leaders wanted bipartisan support (Wang 2012). Governor Quinn formed a task

force on health reform that made a wide variety of recommendations. The Illinois legislature also set up a bipartisan study committee dealing with the insurance exchange (Johnson 2011). 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-based solution (Olsen 2011a). However, concerns about the capacity of the exchange as well as Republican opposition in the legislature raise doubts about the ability of the state to move forward (Olsen 2011b). Nonetheless, Illinois received a $5.1 million federal Level One Establishment Grant. The state received another grant worth $32.8 million in May 2012.

Under Governor Mike Beebe (D) 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 also introduced in the Democrat-controlled legislature but failed (Moritz 2011b). In the face of the Arkansas super-majority 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 state surgeon general, the Arkansas Hospital Association, Arkansas Blue Cross Blue Shield, Delta Dental, the Independent Insurance Agents of Arkansas, the Arkansas Pharmacists Association, and the Arkansas Dental Association strongly supported the creation of a state-based exchange. Facing strong Republican opposition Commissioner Bradford first

moved towards a federal-state hybrid approach for the state (Moritz 2011a) and then, in December 2011, announced that all efforts to establish a state-based exchange had failed and Arkansas would rely on the federal government to create the exchange (DeMillo 2011). However, the state received a Level One Establishment Grant worth $7.7 million in February 2012.

No Exchange Created and Joined Lawsuit

Twenty-four states have failed to establish an exchange while joining the ACA lawsuit:[56] Alabama, Alaska, Arizona, Florida, Georgia, Idaho, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah,[57] Virginia, Wisconsin, and Wyoming. In all 24 states the Governor is a Republican and in all but Iowa, Mississippi, and Wyoming the attorney general is Republican as well. In all three of the latter cases, the lawsuit was joined by the respective governor directly after a change in the governor's party after the November 2010 elections. In all but Iowa and Mississippi, Republican majorities control both chambers of the legislature.[58]

Nonetheless, eight states received Level One Establishment Grants. In twelve states, departments of insurance have received grant funding. Governors also joined in a letter by the National Governors Association (NGA) to HHS Secretary Sebelius requesting more support from the federal government ("State Governors Call for Federal Help in Setting Up Benefit Exchanges" 2011) and a few states participated in an NGA technical retreat on exchanges (Manos 2011). Many of these states have made extensive use of foundation funding, for example through the Robert Wood Johnson Foundation, particularly for technical expertise ("Grantwatch: How Foundations Are Helping States Implement Health Insurance Exchanges" 2012; Weaver

2011). Moreover, all states but Florida and Louisiana have created entities to study their options and undertake exchange planning. In many cases the department of insurance has been a hub for planning. Tea Party opposition appears to have played a particularly prominent role in preventing a more open and deliberate attempt at moving forward.

Several interesting cases stand out. In Oklahoma Governor Mary Fallin (R) 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 Innovators Grant of $54.6 million (McNutt 2011a) and legislation was introduced and passed the Oklahoma House. However, Tea Party activists and several Republican legislators vocally raised concerns about accepting any federal money or engaging in activity that could be interpreted as any form of cooperation with the Obama Administration (Greene 2011a). Particularly Governor Fallin, who had voted against the ACA as a member of Congress, saw herself confronted with intense criticism (McNutt 2011a). Moreover, in a constitutional referendum Oklahomans also overwhelmingly voted in opposition to the ACA against individual and employer mandates in November 2010. In view of such intense opposition, Governor Fallin returned all federal funds and instead announced her support for a privately- or state-funded approach (McNutt 2011b, 2011c). After several failed attempts, the legislature agreed to the creation of a joint committee to study the state's options. The committee initially failed to provide an official recommendation yet a majority appeared to favor the creation of a state-based exchange echoing earlier justifications by Governor Fallin and other high-ranking officials with respect to federal intrusion (Greene 2011b). The committee eventually recommended creation of a state-based exchange ("Committee calls for Okla. insurance exchange" 2012). Oklahoma was also the second state to

enter in an interstate compact following Georgia in an effort to restrict federal healthcare regulation (Ingram 2011) and restricted abortion coverage in any future exchange. However, the current proposal is out of compliance with the ACA because it does not allow consumers to receive federal subsidies.

The implementation trajectory in Kansas closely resembles that of Oklahoma. Initially the state was moving along swiftly with its plan to develop a state-based exchange and it even received an Early Innovator Grant for $31.5 million. As in Oklahoma, Governor Sam Brownback (R), who also voted against the ACA when in Congress, returned the state's Early Innovator Grant (Millman and Nocera 2011) and the legislature restricted abortion coverage in any future exchange as pressure, particularly from Tea Party activists, mounted. However, the Kansas legislature has expressed support for the utilization of federal grants for further study (Shields 2011). Extensive planning efforts continue nonetheless with multiple working groups directed by the moderate Republican state insurance commissioner Sandy Praeger, who has been supportive of the concept of an exchange (Meyer 2011). Moreover, Kansas has contracted for the Kansas Eligibility Enforcement System, a $135 million computer system almost entirely funded by CMS with similar technological requirements as a health insurance exchange (Fields 2011).

Two states, Louisiana and Florida, have steadfastly refused to comply with the ACA requirements for 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 in March 2011 officially refusing to create a state exchange (Moller 2011). Louisiana also refused to create a state-based high-risk insurance pool as part of the ACA.

Moreover, it was one of the initial thirteen states filing a lawsuit against the ACA. Louisiana's Attorney General James Caldwell has so far been the only Democrat joining the lawsuit, although he recently switched party affiliations to become a Republican. The state also passed a law prohibiting the offering of abortions by insurance plans participating in any future exchange.[59] Nonetheless, the state passed legislation to increase the age limit for dependent children coverage to 26 and barred insurance companies from denying coverage due to pre-existing conditions (Brumble 2012). Moreover, Insurance Commissioner Jim Donelon is seeking authority to review and deny excessive insurance premium increases (Brumble 2012). However, against the wishes of Governor Jindal (R) and the secretary of the state Department of Health and Hospitals, Bruce Greenstein, the legislature introduced legislation[60] establishing an exchange in 2012 (Ballard 2012). However, the Republican Senate strongly rejected the effort.

Florida has been the most vocal state in opposition to the ACA and has taken the lead in the lawsuit filed by thirteen states the day after its enactment. Particularly Florida Governor Rick Scott (R), a former Columbia/HCA executive, has persistently refused to implement any component of the ACA. According to the Florida Center for Fiscal and Economic Policy, Florida has rejected $18 million to $23 million in grant funding from the ACA for a wide variety of purposes (Florida Center for Fiscal and Economic Policy 2011). Nonetheless, the state enacted restrictive abortion provisions for health plans participating in any future exchange.[61] 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, adopted legislation would allow the state to establish an exchange should the ACA be upheld in

court (Sexton 2012). Moreover, the state is budgeting more than $30 million in Medicaid IT upgrades (Sexton 2012) which would facilitate eventual compliance with ACA requirements.

Finally, exchange activities in Mississippi have differed markedly from other states as Commissioner of Insurance Mike Chaney (R) announced that the state would establish a Health Insurance Exchange 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. However, the legislature also created a Health Insurance Exchange Study Committee[62] and the House[63] and the Senate[64] 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 (Harrison 2011). Recently, against his statements just after the Supreme Court verdict, Chaney announced a halt to implementation until after the presidential elections ("Chaney: Exchange's future comes after election" 2012). Both bills had passed their respective chambers with strong support ("Mississippi House OKs insurance exchange" 2011).

Former Governor Haley Barbour (R) has been supportive of the exchange efforts and grant applications and together with Commissioner Chaney has emphasized the benefits for the state ("Launch near for health care exchange" 2011). The state has been actively moving forward with its planning activities. The state also obtained a Level One Establishment Grant of $20 million.

State Implementation and Federalism

Following a long tradition in American social welfare policy, the ACA relies extensively

on the cooperation of states for implementation over long periods of time (see Haeder 2012). As outlined by the ACA and subsequent rules, states have the option to choose between implementing a state-based exchange, defer implementation to the federal government, or opt for various hybrid forms (Center for Consumer Information and Insurance Oversight 2012a). States are required to submit their intentions by November 16 2012, more than a year before actual implementation and just days after the presidential elections (Center for Consumer Information and Insurance Oversight 2012a, 4). Various reasons for the federal approach have been proposed. For example, based on a set of criteria they developed including social justice, procedural democracy, and economic sustainability, Greer and Jacobson (2010) concluded that only the federal government has the capacity to develop and sustain major coverage initiatives. Moreover, a federalist approach served as a "political counterweight to charges of a federal takeover" (Sparer 2011, 465). States also lobbied extensively to gain greater control and influence (Dinan 2011). In addition, strong reliance on states may have been necessary to win over moderate and conservative Democrats by moving the ACA further to the right (cf. Brady and Kessler 2010). Finally, it has been argued that "political fragmentation […] produces new intergovernmental partnerships that, in turn, produce incremental growth in overall government involvement in the health care arena" (Sparer, France, and Clinton 2011, 33). This phenomenon has been termed "catalytic federalism" (Nathan 2005; Sparer, France, and Clinton 2011)

Although this federal approach offers significant potential to provide for local adaptations, it also creates a number of roadblocks. These roadblocks may be the result of deliberate state opposition or a sheer lack of capacity in resource-strapped states suffering economic woes with only recently elected officials (see Haeder 2012). Robert McGrath (2009)

finds in his case studies of State Children's Health Insurance Program (SCHIP) implementation in Georgia, Massachusetts, and Ohio that state capacity and programmatic experience affected implementation and administration. Malcolm Goggin (1999) also evaluates the implementation of SCHIP and finds that efforts are strongly affected by politics and, to a degree, economic conditions in a state whereas need has little effect. Moreover, in their analysis of state healthcare PACs David Lowery and his colleagues (2009) have shown that PACs and lobbying are systematically skewed towards providers and drug and medical device manufacturers with potentially significant implications for the development of state exchanges as only 1 percent of PACs belong to advocacy groups. The case of Louisiana's public hospital system after Hurricane Katrina also illustrates nicely that special interests significantly shape reform implementation (Clark 2010). Perhaps one of the most vivid examples of state opposition has been presented by the governors of states like Louisiana, Texas, and Florida who have steadfastly refused to comply with almost all requirements under the ACA even after the Supreme Court ruling.

Public Administration in the Face of Adverse Politics

Despite their pivotal role in the healthcare 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. For example, eleven insurance commissioners are elected directly while most of the rest are appointed by the governor. In a majority of cases, legislative confirmation is required. Moreover, insurance departments differ significantly in terms of staff and budgets from a low in Wyoming with 27 FTE and South Dakota with $1.8 million to California with more than 1,700 FTE and $153

million, respectively, in 2010. Adjusted by state population, the respective numbers differ from a low of 14.5 FTE to 220 FTE per million residents in Arizona and West Virginia and $1.4 million to $11.1 million per million residents in Indiana and Vermont.

In virtually every state, insurance commissioners and their staffs have played critical roles in preparation and planning for insurance exchanges. Their efforts have included rhetorical leadership, conducting stakeholder meetings, general research, and acting as a liaison with HHS among many others. Insurance commissioners have also taken leadership roles in many of the task forces or commissions established by governors and legislators to support state decision making in the implementation of the ACA in general and exchanges in particular. Many insurance commissioners have been actively lobbying for their states to adopt insurance exchanges instead of relying on the federal fallback option. Insurance Commissioners like Sandy Praeger in Kansas and Monica Lindeen in Montana, like many others, have done so despite strong opposition in their states from state governors and legislators. West Virginia even established its exchange within the Offices of the Insurance Commissioner. Finally, Mississippi Commissioner of Insurance Mike Chaney (R) announced that the state would establish a Health Insurance Exchange regulated by the Insurance Department without further legislation.

The critical role of insurance commissioners becomes evident when taking a look at the state agencies receiving federal exchange grants. The insurance department was the recipient for 22 of the 46 planning grants, 14 of the 43 Level One grants,[65] and 1 of the 2 Level Two grants. Overall, 25 of the 46 states that received grants utilized their insurance department as a grant recipient, particularly at the early stages of planning. Insurance commissioners have been particularly important in states that have joined the lawsuit against the ACA. Out of 19 states that

received planning grant funding, 11 used their insurance departments as administrators whereas out of the ten states that received Level One grants, three used their insurance departments as administrators. 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 7 planning grants (out of 12) and 4 Level One grants (out of 10).

Only a small number of insurance commissioners have been openly opposed to the implementation of state-based exchanges. Some of them, like Mary Taylor (OH), who is also the lieutenant governor, have utilized their position as a podium to express their general opposition to the ACA. Taylor also returned federal grant funding to support implementation of the ACA including the planning grant funding. 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.

An Empirical Evaluation 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 Supreme Courts' ruling in June 2012. As the number of observations is relatively small, we include only four 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—other things equal, states that joined the lawsuit will be less likely to have established exchanges. Second, the Number of Mandates[66] counts the health insurance mandates adopted by the state. 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 per million people in the state.[67] It has a mean of 4.7 and a standard deviation of 2.4. We expect this variable to have a positive coefficient. Fourth, we include the Herfindahl-Hirschman Index (HHI)[68] 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 that the dominant firms will apply in support of the exchanges because it provides insurers with smaller market shares to compete more effectively.

Table 2 summarizes the results of the logistic regression. Note that all of the coefficients (and hence the marginal effects) have the predicted signs. Using one-tailed tests (and stretching significance to the 10 percent level in the case of the per capita budget and HHI), all of the variables are statistically significant. The last column of the table provides an indication of the substantive importance of the marginal effects of the variables, holding the other variables at their means. So, for example, a state that joins the suit is 30 percentage points less likely to establish an exchange. The largest marginal effects in terms of comparing a state that is one standard deviation below the mean to one standard deviation above it occur for the number of

mandates and HHI, 39 and 31 percentage points, respectively. 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 23 percentage points.

(Table 2 about here)

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

Will Exchanges be Operating on January 1, 2014?

Not surprisingly, the implementation in the states has been controversial and exchange activity has varied significantly. Only 13 states[69] led by California have at least rudimentary exchanges in place but the enabling legislation often leaves many implementation decisions for the future. Simultaneously, Louisiana, Florida, and Arkansas have announced that they will rely on HHS to establish exchanges. A significant number of other states including Ohio and South Carolina have been openly defiant. Others including New Hampshire, Oklahoma, Kansas, and Wisconsin have returned significant grant funding. Several states have passed legislation, referenda, or even constitutional amendments to limit or even prohibit cooperation in the implementation of the ACA.[70] Most states have refused to pass or even introduce legislation citing concerns about the future of the ACA in courts and Congress; Tea Party opposition has

been rampant. Ironically, the states most reluctant to cooperate with the implementation of the ACA are also those whose populations have the largest potential to benefits from the various ACA provisions, particularly those affecting the exchanges and Medicaid (Blavin, Buettgens, and Roth 2012)

If states fail to create insurance exchanges, HHS will implement a Federally-facilitated Exchange (FFE) either on its own or in partnership with the respective state based on a set of four guiding principles: (1) commitment to consumers, (2) market parity inside and outside the exchange, (3) leveraging traditional state roles, and (4) engagement with states and other stakeholders (Center for Consumer Information and Insurance Oversight 2012b, 4). According to the guidance issued by HHS (Center for Consumer Information and Insurance Oversight 2012b), 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 the provision of consumer assistance. However, "HHS, by law, retains authority over each FFE" (Center for Consumer Information and Insurance Oversight 2012b, 6). Federally-operated exchanges, will initially employ an open market model accepting all health plans meeting minimum qualifications and utilize traditional health insurance brokers and agents (Center for Consumer Information and Insurance Oversight 2012b). However, health plans participating in an exchange will be responsible for meeting both existing state and federal exchange requirements.

One of the major concerns is the lack of electronic eligibility systems in some of the

states, which will greatly impede exchange implementation even under the partnership or fully federal models. Yet, because of the enormous amounts of information exchanged between a multitude of federal and state agencies, including state Medicaid offices, HHS, and the IRS, and private health plans, the most crucial component of health insurance exchange development is the merging of IT systems. Despite opposition to the ACA in many states, HHS has been able to move forward on this issue utilizing Medicaid funding to support state IT upgrades as from April 2011 to December 2015 Medicaid provides enhanced 90/10 matching funds for new development of upgrading of Medicaid eligibility systems (Heberlein et al. 2012). Moreover, enhanced 75 percent matching for ongoing maintenance will continue indefinitely. As of January 2012, 19 states were approved for funding and an additional 10 states had submitted applications (Table 3). Interestingly, included in this list of states are some of the staunchest opponents of ACA implementation including South Carolina, Louisiana, Oklahoma, and New Hampshire. As a result, many states may be further along in their preparations for health exchanges than publicly acknowledged. However, the utilization of outdated legacy IT systems, real-time enrollment, and interoperability and connectivity problems may prove to be a significant hurdle in the implementation process (Feder 2012b).

(Table 3 about here)

Nonetheless, currently, in view of the limited implementation efforts undertaken by many

states, the federal partnership model may become the dominant model as many experts are generally skeptical that that majority of states will be able to achieve certification given the mid-November deadline from HHS (Feder and Millman 2012). This holds even more so for states like Wisconsin, Florida, and Nebraska, whose governors have expressed that they will continue to stall implementation until after the presidential election in November. 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 granted to HHS in implementing the exchanges. It is equally ironic that the most conservative states, those that totally refuse to cooperate on implementation, may end up with significantly more liberal exchanges due to the leadership of HHS. However, there are concerns about the capacity of these 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. HHS quickly moved away from its plans and instead will allow states to continue Medicaid enrollment if they meet certain requirements (Feder and Millman 2012). It will also be interesting to see whether states choose to go ahead with the Medicaid expansion and how eligibility issues will be solved in states that do not expand their threshold.

At the same time, various states, including California, Massachusetts, Washington, Oregon, and Hawaii, have made significant progress towards fully implementing their own exchanges. Foundations have provided significant resources and garnered expertise since the enactment of the ACA and may prove crucial, for example, through tools like *Enroll UX 2014*[71] developed under the auspices of the California HealthCare Foundation. Moreover, health plans

are actively preparing for the establishment of exchanges. Many 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 plants 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).

Conclusion

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 research shows, not all insurance commissioners were equally successful in participating in the implementation effort. Capacity as measured by per capita budget and the number of state mandates plays a significant role. The vast differences in resources between states are a reason for caution, however. 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 the American Legislative Exchange Council in policy implementation deserve further attention.

Looking ahead, the importance of exchanges is not limited to the implementation of the ACA. Exchanges hold tremendous potential to improve dramatically the American healthcare system. While exchanges are intended to provide coverage to millions of persons 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, information asymmetry, and adverse selection, exchanges can potentially provide a viable, transparent, and competitive marketplace for the purchase of insurance for all Americans. Exchanges would allow the nation to move away from current employer-based system with its significant shortcomings (for example see Reinhardt 2009; Villegas 2009) and allow for vigorous competition based on quality and price. To the extent that exchanges actually reduce insurance costs, they will help reduce the number of individuals who are un- and underinsured (see Daniels 1985). 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 healthcare woes that could be embraced by both liberals and conservatives.

Appendix

A note on private exchanges: Private companies have also moved forward in developing health insurance exchanges or in expanding their presence in the market. These efforts are a response to growing demand from employers for more choices at lower cost (Kramer 2012).For example, WellPoint, Inc., Health Care Service Corp. and Blue Cross Blue Shield of Michigan purchased stakes in Bloom Health, a relatively new online marketplace that provides coverage options to 20,000 workers and almost 50 companies (Wechsler 2011). Microsoft ("bswift, Microsoft Join Forces to Provide Health Insurance Exchange Solutions" 2011), Highmark, Inc. (White 2011), and consulting firm Aon Hewitt (Appleby 2011a) also decided to enter the exchange business and Blue Cross and Blue Shield of Kansas City launched the Blue KC Exchange (Stafford 2011). In addition, UnitedHealth Group bought Connextions, a company with expertise in private exchanges (Hsu 2012). Overall, private exchanges have a presence in more than 20 states (Appleby 2011a). Private exchanges provide opportunities for employers to offer defined contributions to their employees and have them select their plans. 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.[72]

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[1] Author's calculations from a variety of sources including the Kaiser Family Foundation, HHS, and the National Conference of State Legislatures (NCSL)
[2] Note: Specific guidance to states was provided by Centers for Medicare and Medicaid Services in 2012 (Center for Consumer Information and Insurance Oversight 2012a).
[3] §1311(b)
[4] §1304(b)(2)
[5] §1311(b)
[6] § 1304(b)(3)
[7] Blavin, Buettgens, and Roth (2012) estimate that merging both exchanges will increase affordability and lead to about 1 million fewer uninsured individuals. Other variations analyzed have much more limited effects.

[8] §1312(c)
[9] §1321(c)
[10] §1311(d)(1)
[11] §1311(f)(1)-(2)
[12] §1311(f)(3)
[13] §1311(d)(5)
[14] §1311(d)(6)
[15] §1313
[16] See Corlette and Volk (2011)
§1311(d)(4)(A)-(E)
[18] §1311(d)(4)(F)
[19] §1311(d)(4)(G)-(H)
[20] § 1413
[21] §1311(d)(4)(K), 1311(i)
[22] §1311(a)
[23] §1311(c)
[24] §1311(c)(1)
[25] §1311(c)(3)
[26] §1311(c)(4)
[27] Recent guidance by HHS has pushed back quality of care reporting to 2016 (Center for Consumer Information and Insurance Oversight 2012b, 11)
[28] §1311(c)(5)
[29] §2794(b)
[30] § 1302
[31] §1311(d)(2)
[32] §1301 and §1311
[33] §1311(e)
[34] §1301
[35] §1301
[36] §1302
[37] §2001
[38] Health and Education Reconciliation Act of 2010 §1001
[39] *National Federation of Independent Business et al.* v. *Sebelius, Secretary of Health And Human Services, et al.* 576 U.S. (2012), 58–59.
[40] Although states may choose a lower ratio
[41] §2701
[42] §45R
[43] §1311(d)(3)
[44] §1312(d)(D)
[45] §1312(f)
[46] §1341-43
[47] We considered the Massachusetts Connector as in compliance with the ACA as the state is currently working towards the required minor modifications.
[48] The exceptions include Rhode Island and Oregon.
[49] Executive Order 11-09
[50] Executive Order 42
[51] Legislation in Vermont includes health system reforms beyond the exchange.
[52] Executive Order 11-01
[53] SB 580
[54] Illinois SB 1555
[55] Illinois SB 1729

[56] Virginia filed a separate law suit
[57] Although Utah has established an exchange it is out of compliance with the ACA and the state has not worked towards bringing it into compliance.
[58] Nebraska has a unicameral legislature that is technically non-partisan.
[59] Louisiana HB 1247. Regular Session, 2010
[60] Louisiana Senate Bill 744
[61] Florida HB 97/SB 1414
[62] Mississippi HB 377
[63] Mississippi HB 1220
[64] Mississippi SB 2992
[65] Many of the Level One grants go directly to the newly established exchange
[66] Data were obtained from the Council for Affordable Health Insurance (CAHI)
[67] Data were obtained from the annual Insurance Department Resources Report published by the National Association of Insurance Commissioners
[68] Data were obtained from the Kaiser Family Foundation
[69] Excluding Utah and Massachusetts
[70] The NCSL provides a relatively current overview at http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-aca.aspx
[71] http://www.ux2014.org/
[72] Test

Table 1: Legal Position and Implementation Progress

	Exchange Established	Exchange Not Established	
Joined Lawsuit	Colorado	Alabama	Nebraska
	Indiana	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	New Mexico
	Connecticut	Delaware	North Carolina
	Hawaii	Illinois	Tennessee
	Maryland	Kentucky	
	Massachusetts	Minnesota	
	New York	Missouri	
	Oregon	Montana	
	Rhode Island	New Hampshire	
	Vermont	New Jersey	
	West Virginia		

Source: Authors, various sources. June 2012.

Table 2: Factors Affecting Probability of Timely Exchange Establishment (Logistic Regression)

Variable	Coefficient	Standard Error	Percentage Point Change (all other variables at means)	
ACA plaintiff	-1.96**	.874	No to Yes	-30
Number of mandates	.105**	.039	± 1 S.D.	+39
Budget per million persons	.331*	.190	± 1 S.D.	+23
HHI in thousands	-.691*	-.367	± 1 S.D.	-31
Constant	-3.76*	2.12		

N=50, Pseudo R^2=.35, 84% correctly classified, 57% sensitivity, 94% specificity

** Statistically significant at the 5 percent level (one-sided test)

* Statistically significant at the 10 percent level (one-sided test)

Table 3: Status of Major Medicaid Eligibility System Upgrades, January 2012

States without ACA Level One Grants (16 states)	Approved Advance Planning Document (19 states)	Submitted Advance Planning Document (10 states)	Plan to Submit Advance Planning Document Next Year (18 states)	Not Considering at this Time (3 states)
Alaska	Oregon	Alaska	Washington	Utah
Florida	Nevada	Texas	California	Maine
Georgia	Montana	South Dakota	North Dakota	Florida
Kansas	Wyoming	Minnesota	Idaho	
Louisiana	Arizona	Wisconsin	Colorado	
Montana	New Mexico	Iowa	Missouri	
New Hampshire	Kansas	North Carolina	Arkansas	
North Dakota	Oklahoma	Vermont	Mississippi	
Ohio	Illinois	New Hampshire	Tennessee	
Oklahoma	Kentucky		Michigan	
South Carolina	Louisiana		Ohio	
Texas	Alabama		Indiana	
Utah	Georgia		Virginia	
Virginia	South Carolina		West Virginia	
Wisconsin	Maryland		Pennsylvania	
Wyoming	New Jersey		New York	
	Massachusetts		Connecticut	
	Hawaii		Delaware	
	Rhode Island			

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