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MANAGING HEALTH REFORM

THE OUT-FRONT WESTERN REGION

An Overview

March 2014

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AN OVERVIEW

State-Level Field Network Study of the Implementation of the Affordable Care Act

March 2014

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THE OUT-FRONT WESTERN REGION

An Overview

The U.S. Census Bureau defines four main regions of the country — the West, South, Midwest, and Northeast. This first "Special Analysis Report" focuses on the Western region, which has the largest number of states — six out of thirteen — that are affirmatively implementing the Affordable Care Act. That is, they have state-administered health insurance exchanges and have expanded Medicaid as authorized under the law.

Altogether, there are eleven states in the Western region of the contiguous states, and nine of them are in our sample. A complete list of states of the Western region and those of our sample is contained in Table 1 (see next page).

This report describes the policy setting and goal alignment of all nine Western sample states, with emphasis on five states — California, Oregon, Washington, Colorado, and Nevada — that are clearly out front as ACA-affirming states. New Mexico is also an affirming ACA state, although its exchange will not be state run until 2014. Arizona and Idaho occupy an "In-Between" category; that is, in between affirming and oppositional. Arizona rejected the state-run exchange option but accepted Medicaid expansion. Idaho so far has done the opposite, accepting the state-run exchange option while tabling Medicaid expansion. Utah is the one fully oppositional state in our sample, choosing in 2013 not to run its exchange or expand Medicaid. As shown in Table 1, by one index of "enrollment performance" (the number of individuals who have selected a plan as a percentage of the potential market size during the first month of operation) four of the six fully affirming Western states rank among the top ten states.

Table 1. Western States Goal Alignment with the Affordable Care Act and Initial State Enrollment Performance Rank, as of October 31, 2013

State/General Response	Exchange*	Medicaid Expansion	Early ACA Enrollment Rank**
Affirming			
California	S	Yes	7
Colorado	S	Yes	8
New Mexico	S&F	Yes	40
Nevada	S	Yes	10
Oregon	S	Yes	no data
Washington	S	Yes	5
In-between			
Arizona	F	Yes	28
Idaho	S	No	18
Oppositional			
Utah	F	No	37

* S = state run exchange, F = federally run exchange, S & F = federally supported by the HealthCare.gov Web site in 2013, transitioning to full state support in 2014.

West Region — U. S. Census Bureau:
- *Mountain Division*: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming
- *Pacific Division*: Alaska, California, Hawaii, Oregon, and Washington

This essay and the first set of Western state reports that appear with it largely focus on events and data for the period October 1, 2013, to October 31, 2013, the first month of major coverage expansion and the opening of ACA marketplace exchanges. Our subsequent reports will provide periodic updates and new data for important trends such as enrollment as a percentage of potential market size by state.

** Initial state ACA enrollment rank reflects the number of individuals who enrolled in an ACA exchange plan as a percentage of the potential market size, by state. Market size is taken from estimates made by the Kaiser Family Foundation. State ranks are from one to fifty, with Vermont leading the list. Of the top ten, four are in the West, four in the Northeast, one in the South, and one in the Midwest.
The state rankings are based on the first month enrollment period October 1, 2013, to October 31, 2013. Calculations triangulate data from the following sources: Congressional Budget Office May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage; Kaiser Family Foundation November 2013 Issue Brief, State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act; Department of Health and Human Services Issue Brief, Health Insurance Marketplace: November Enrollment Report.

The field research reports described in this Special Analysis Report contain individual state stories and baseline data covering the first month of exchange operations under the Affordable Care Act. The information can be accessed from the Special Analysis Report or by using the network map available on the project Web site (http://www.rockinst.org/aca/). Initial Round 1 reports for sample states from other regions will be announced and posted along with future Special Analysis Reports. You can receive announcements of both types of reports by emailing info@rockinst.suny.edu.

State Capacity for Affordable Care: Where Did It Come From, Where Is It Going?

What accounts for this apparent fast start of Western states in implementing the ACA? For the three years leading to up to initiation of ACA insurance exchanges and Medicaid expansion, political rhetoric about the perils of Obamacare and the importance of states' rights were at least as pervasive and intense — perhaps more so — in the West as in other regions. Yet once the Supreme Court decision and the presidential election affirmed that the ACA would proceed, implementation of health care reform continued for the most part in this region despite ongoing political resistance. In our future inquiry, we intend to look closely at this dynamic to refine our understanding of the place and power of professionalism in intergovernmental implementation.

In this early period, our Nevada field associate, Leif Wellington Haase, sees a "blend of rhetorical skepticism and operational pragmatism" at work in Nevada's decision to accept a state-run exchange and Medicaid expansion. This duality is apparent in other Western states such as Idaho, New Mexico, and Arizona where Republican governors and legislative leaders have tended to continue proclaiming their personal opposition to Obamacare, while advocating alignment with state-run exchanges, Medicaid expansion, or both.

Clues for understanding the Western response to the ACA can be found in the following capsule descriptions of our sample states. Reading these capsules is only an introduction to the stories of each state. In the month of October 2013, major similarities and differences among the Western states were apparent, as were expected and unexpected outcomes of early implementation efforts described in the full state reports.

Implementation of the Affordable Care Act, Pre-2014

California: Affirming

Field Research Associate Micah Weinberg, Healthy Systems Project, Inc.

In September 2010, six months after passage of the ACA, California became the first state to create its own insurance exchange. Speed has been the hallmark of California's ACA

implementation. Operating under the cover of wide general agreement among the Democratic-controlled legislature and Republican Governor Arnold Schwarzenegger and his staff, and later Democratic Governor Jerry Brown, California moved quickly to take advantage of substantial federal funds associated with ACA.

The state also moved swiftly to develop and control an exchange, following earlier state health policy deliberations. A broad range of stakeholders and interested organizations helped to plan the exchange, which would operate as an active purchaser that would negotiate the best price for enrollees. Despite general agreement among key legislators, staff, and multiple organizations with abundant experience in California health care reform, opposition appeared frequently in hearings and forums associated with enabling legislation for the state exchange. Opponents were particularly vocal about the structure and governance of state exchanges; the number of insurance markets and exchanges; mitigating adverse selection; coordination with state public programs; and other issues.

ACA planners had a full agenda. Among other things, they needed to consider the link between the ACA and existing county-based health programs in directing potential Medicaid expansion recipients to those programs. And they had to ensure the Exchange's eligibility and enrollment functions interacted with Medi-Cal (California's Medicaid program), Healthy Families, and other public programs. During initial implementation, many of the California Health and Human Services Agency staff wore "2014 Is Tomorrow" buttons to convey a sense of urgency. Creating the exchange was a massive undertaking, even for a state like California that had a significant jump on the process. Among other Western states with fast starts, California is truly an early leader.

Colorado: Affirming

Field Research Associates Jeff Bontrager, Kevin Butcher, and Sara Schmitt, Colorado Health Institute

Colorado's decisions to develop its own exchange and expand Medicaid are consistent with the state's long-term approach to health care reform. Prior to the ACA, the state initiated reform efforts, most with bipartisan support and sponsorship, including incremental expansions in Medicaid eligibility and creation of a high-risk pool. In 2008, a bipartisan commission recommended a state-based health insurance exchange, though it didn't gain traction. Following passage of the ACA in 2010, the state passed legislation creating a state exchange. The decision to expand Medicaid in 2013 drew only one Republican vote, but passed due to Democratic majorities in the legislature and a Democratic governor.

Although debate over the ACA and earlier health reform efforts has, at times, been contentious, Colorado has historically

reached general political agreement on issues that benefit Coloradans. Legislators and stakeholders have negotiated over time to develop multiple new approaches to health reform that are generally well aligned with the ACA.

Nevada: Affirming

Field Research Associate, Leif Wellington Haase, New America Foundation

Following passage of the ACA, Nevada became the only state with a Republican governor to set up its own state exchange and to expand the state's Medicaid program.

Governor Brian Sandoval's stance was pivotal. Sandoval chose to implement a law he personally opposed, with the aim of giving Nevada maximum autonomy in setting up and administering the new health insurance marketplace. Sandoval's decision reflected, in large part, the circumstances of a state where the recession hit particularly hard. Nevada has strongly supported an active outreach program, which in part is responsible for the relative strong ACA enrollment rank of tenth highest among all states by October 31, 2013.

New Mexico: Affirming

Field Research Associates R. Burciaga Valdez and Gabriel R. Sanchez, Robert Wood Johnson Foundation Center for Health Policy

Health care reform is not new to New Mexico. Former Governor Bill Richardson attempted to reform the health care system during his second term. In addition, New Mexico established a quasistate agency, the New Mexico Health Insurance Alliance (NMHIA), in 1994 to function as an individual insurance exchange.

In 2012, the state proposed to the Centers for Medicare & Medicaid Services (CMS) that the NMHIA serve as the state's ACA exchange. Legislators and the state attorney general raised concerns about conflicts between the original state-enabling legislation for the insurance alliance and the ACA. This was resolved in 2013 with the development of a new exchange, the New Mexico Health Insurance Exchange (NMHIX), a quasigovernmental nonprofit public corporation.

The NMHIX operates the small business health options component and it relies on the federal platform for the individual market. New Mexico requested and received federal information technology support for individual enrollment in 2013 and plans to transition to full state-run status in 2014.

Governor Susana Martinez broke from Republican governors who oppose the ACA when she announced in early 2013 that New Mexico would expand Medicaid as long as the federal government provided the funding for the initial expansion. "The election is over and the Supreme Court has ruled. My job is not to play party politics, but to implement this law in a way that best serves New Mexico."[1]

Oregon: Affirming

Field Research Associates Billie Sandberg and Jill Rissi, Mark O. Hatfield School of Government, Portland State University

Oregon has taken an affirmative response to the ACA as evidenced by its enthusiastic development and implementation of Cover Oregon in 2011 and its decision to expand Medicaid.

The state has a significant history of health reform deliberations and legislation. Oregon policymakers began discussion and development of a state health insurance exchange in 2004. Legislation forging organizational/structural health reforms followed in 2007 and 2009. Oregon was one of six states to receive a Model Testing award from CMS[2] to support transformation of its health care delivery system through innovation. Development of a state exchange was stymied because of lack of funding until the ACA. There was no question about Oregon's desire to operate its own exchange, although a dispute involving some legislators and health insurance interests over whether it should be an active purchaser resulted in a final decision in favor of a clearinghouse form.

Although Oregon actively supports national health reform and is generously funded by CMS, it has had one of the poorest experiences during the first month of ACA implementation because of Cover Oregon's information technology (IT) failures. Oregon Field Research Associates Billie Sandberg and Jill Rissi conclude that Cover Oregon may have tried to develop an overly complicated, do-it-all system, rather than adopt basic functionality. The IT system was inoperable in October and the state used paper enrollment applications, promising applicants they would be served in time to enroll for 2014.

Washington: Affirming

Field Research Associates Aaron Katz, John Stuart Hall, Patricia Lichiello, Health Policy Center, University of Washington

Washington's response to the ACA was also speedy and fully affirmative. The state legislature, with a Democratic majority in both houses, decided to run an insurance exchange in 2011, ahead of the June 2012 Supreme Court decision on the ACA's constitutionality and well in advance of the 2012 presidential election. Governor Jay Inslee strongly supported the ACA when he was in Congress and throughout his gubernatorial campaign in 2012. In that campaign, Inslee ran against the state attorney general, who joined the lawsuit challenging the ACA over the objections by the previous Democratic governor and the state legislature.

Washington has been at the forefront of efforts to reform the health system, expand coverage — Inslee authorized Medicaid expansion on July 1, 2013 — and alter the fragmented structure of health care delivery, all goals of the ACA. The state's Basic Health Plan (a model for the ACA's Basic Health Option) of subsidized health insurance for uninsured,

low-income residents started in 1988 and reached 130,000 enrollees in the early 2000s. Innovations in Medicaid and in comprehensive health reform were called for in state legislation in the late 1980s and early 1990s. Early discussions of exchange development and Medicaid expansion folded well into ACA incentives. The state was ready to implement both and advance its own progressive health reform agenda once the U.S. Supreme Court upheld the ACA's constitutionality. Importantly, individuals in Washington's health care reform community remain central to ACA development. Relatively successful early implementation of the ACA was due in large part to having highly experienced, long-serving professionals with existing working relationships in key positions.

Arizona: In Between

Field Research Associates John Stuart Hall and Catherine Eden, School of Public Affairs, Arizona State University

In many respects, Arizona mirrors Idaho in its conservative Republican-dominated politics, its "in-between" posture of alignment with ACA goals, and the intensity of political battles over ACA choices.

Arizona has taken both partially affirming and partially oppositional responses to major goals of the ACA. After a substantial planning effort funded by CMS, Arizona declined a state-managed exchange and accepted the federally facilitated exchange option. At the end of October 2013, the state appeared to be consciously avoiding active involvement in the development and trajectory of the federally managed exchange. Still, statewide outreach proceeded enthusiastically, propelled by an Arizona foundation's efforts to promote the ACA and develop a large and committed community-based statewide outreach network representing more than 600 organizations. On Medicaid expansion, the state is aligned with ACA policy. The state's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), is engaged with the Cover Arizona network to promote outreach.

This partial goal alignment appears to be the result of both passionate political beliefs, which guided the decision against a state-run exchange, and a strongly supported policy stance to use federal funds to restore recession-based cuts and expand the state's well-known Medicaid effort. For three years, Governor Jan Brewer was one of the most vocal and vigorous opponents of Obamacare, although she approved substantial state planning, supported by federal grants, for a state-run exchange. Then, after jettisoning the exchange, she led the state to adopt Medicaid expansion. Brewer has had to pay a high political price, nationally and locally, for her ACA efforts, yet has found some support for her "statesmanship" in forging a grand compromise despite vigorous objections by many of her own party to Medicaid expansion.

Idaho: In Between

Field Research Associate David K. Jones, University of Michigan School of Public Health

Within minutes of President Obama's ACA bill-signing ceremony, Idaho was among the original states in the multistate lawsuit against the law. Yet almost simultaneously, the state applied for a $1 million planning grant to begin preparations for an insurance exchange. These actions set the stage for one of the longest and intense state ACA battles in the nation.

Idaho, one of the nation's most Republican states, is the only state led by a GOP governor and legislature to choose to run a state exchange. Governor Butch Otter, who joined other Republican governors and public officials in attempting to have the U.S. Supreme Court invalidate the ACA, is now the target of substantial criticism for leading the adoption of a state-run exchange. He will be opposed in the Republican primary by a state legislator who accuses him of wanting to "prop up Obamacare." Otter responds that he had no choice but to implement the ACA after battling it in court to no avail: "There's such a thing as the rule of law; if I could repeal Obamacare I'd do it."[3]

Legislation to create a state-based exchange was signed into law on March 28, 2013, near the end of one of the most contentious legislative sessions in recent memory.

Given the short amount of time before the beginning of open enrollment on October 1st, the Exchange Board decided to rely on the federal exchange during the first year. Officially, this set-up is designated as a federally supported exchange, as opposed to a state-federal partnership or a federally facilitated exchange (i.e., run by the federal government).

State officials are still deliberating on whether or not to expand Medicaid. The legislature, which is in session for just three months each year, adjourned last year without deciding the issue. Opinion is mixed in 2014, though few Republicans are willing to take another tough Obamacare vote before this year's primary elections.

Utah: Oppositional

Field Research Associate, Sven Wilson

As of October 31, 2013, Utah was the only Western state fully oppositional to ACA. Republican Governor Gary Herbert tried, but failed, to convince the legislature to expand its innovative small business exchange to cover individuals. Nor was he able to convince CMS that the small business exchange met the ACA minimum requirements for a state-run exchange. Also, the state chose not to expand Medicaid. Herbert plans to put Medicaid expansion back on the agenda in 2014, saying that "doing nothing (about Medicaid expansion) is not an option."[4]

Note: Our Utah Report is in progress and is not included in this release.

Recipe for Western State Leadership

A review of these capsule descriptions and our full state reports reveal the following ingredients, in varying amounts, have led to early structural alignment with the ACA in many of the Western states:

- History and prior experience developing a structural base, including public programs for health care reform;
- An early start and full use of time before implementation;
- Different degrees of political disagreement, made less significant by coalescing over pragmatic health reform and fiscal goals;
- High quality professional leadership and independent staff;
- Federal funds to offset fiscal pressure;
- Substantive detailed assessment of exchange options and selection of consultants.

Values Leading to Alignment

Our early leading indicators of goal alignment — adoption of state-run exchanges and state expansion of Medicaid — are important. Beyond that, our research on Western states in the first month of formal implementation reveals that some degree of genuine agreement on ACA and state goals for health reform have been reached among various political, staff, and nongovernmental players.

This may rest, in part, on a Western political culture that stresses independence, innovation, self-reliance, local control, pragmatism, populist views of equity and public involvement, and many tools of progressivism, including instruments of direct democracy and nonpartisan elections. This culture and these forces have played an important role in Western politics and policy for well over a century.[5] Many of these features can be interpreted as supporting Western state actions in connection with the ACA, particularly decisions to run state exchanges. As Nevada Associate Leif Hasse points out, that state's Web site language, public framing, and summary documents all go out of their way to distance Nevada rhetorically from the federal project and to affirm "a system designed by Nevadans for Nevadans."

In Idaho, Governor Bruce Otter expressed similar sentiments: "Our options have come down to this: Do nothing and be at the federal government's mercy in how that exchange is designed and run, or take a seat at the table and play the cards we've been dealt. I cannot willingly surrender a role for Idaho in determining the impact on our own citizens and businesses." And this dynamic is not reserved for Republican oppositionists. Other Western states, including those that have actively

supported federal development of the ACA and President Obama, have been equally zealous in developing their own "home grown" structures for marketplaces and outreach.

While holding these views of state independence and the importance of state control and innovation, each of our out-front Western states must work with the many other governments and private and nonprofit health and medical interests with high stakes in ACA outcomes. The ACA, which easily ranks among the most complex of public policies, is being implemented in an intergovernmental environment that requires significant cooperation and defies dominance by one government or organization. California Associate Micah Weinberg reports on that state's effort to be the "lead car" in implementation of federal health care reform. "Because of the speed with which it approached this task as well as the sheer size of its coverage expansion, the decisions California has made have been influential both regionally and nationally."

Experience and Resources Count

Each of our out-front states has been significantly engaged in health reform efforts in the recent past, some beginning in the early 1980s. In California, Colorado, Oregon, Washington, and New Mexico, decisions to develop state-run exchanges and to expand Medicaid are consistent with each state's long-term approach to health care reform. Even in the in-between state of Arizona, the politically treacherous decision to expand Medicaid can only be understood in the context of past development of that state's well-known experiment in health care cost containment via precapitated Medicaid.[6]

Importantly, it is not just alignment of previous programs and health reform goals with the ACA that motivates these decisions, but also the perception, and to some degree the reality, that those earlier efforts were homegrown state programs. This type of alignment between earlier efforts and the ACA is real, but so is the pragmatic appraisal that the ACA is not perfect, yet is a major resource to be tapped for the continuation of worthy state efforts.

Table 2 lists some of the major structural dimensions of the West's six state-run exchanges as of October 31, 2013 (see next page). It is clear that substantial financial and human resources have gone into the planning and development of information technology, training, outreach, communications, and other exchange functions. Each of these functions must not only be technically reliable and effective, but also be professionally managed to form a well-connected system so exchanges work in the long term. Although each new exchange requires similar resources, Table 2 describes different levels of financial and human investment and different choices about priorities and functions. The full state reports reveal the diversity of function and range of expertise. It will be instructive to review the functional specialties of exchange staffs to understand the public management collaboration challenge for the ACA.

Table 2. Exchange Structure in the Western States

CALIFORNIA
Exchange Name: Covered California
Form: Independent nonprofit, active purchaser, standardized insurance products.
Board: Five members appointed by the governor and state legislative leaders.
Staff: Board-appointed CEO; civil service exchange staff hired for range of functions; some in-kind assistance from state agencies.
Major funding: $910 million in federal grants through 2014; must be self-sustaining by 2015.
Principal contractor, system integration/project management: Accenture, CGI.

NEW MEXICO
Exchange Name: BeWellNM – New Mexico Health Insurance Exchange (NMHIX)
Form: Hybrid state-run health exchange that operates as a quasigovernmental nonprofit public corporation, clearinghouse.
Board: Twelve members appointed by the governor and legislature.
Major funding: $62,849,354 in federal grants though 2014.
Principal contractor, system integration/project management: GetInsured.

COLORADO
Exchange Name: Connect for Health Colorado.
Form: Independent nonprofit, clearinghouse.
Board: Twelve appointed members.
Staff: Executive director appointed by the board; three-member executive team; more than thirty staff in organization and more than 160 representatives in customer service center.
Major funding: $178 million in federal grants; one of ten states to receive technical assistance from the Robert Wood Johnson Foundation's State Health Reform Assistance Network.[7]
Principal contractor, system integration/project management: CGI

OREGON
Exchange name: Cover Oregon
Form: Quasigovernmental, clearinghouse
Board: Nine members appointed by the governor and confirmed by the legislature.
Staff: Executive director appointed by the governor; 185 full-time staff; 100 temporary; unspecified number of special functions contracted out; 400 temporary hires authorized in October to fill out paper applications in lieu of the IT system.
Major funding: $242 million in federal grants plus related Model Testing grant.
Principal contractor, system integration/project management: Oracle

WASHINGTON
Exchange name: Health Benefit Exchange (HBE)
Form: Quasigovernmental, public-private partnership exempt from certain state operating rules, clearinghouse.
Board: The eleven-member Board comprises health care industry experts and includes a chair, eight members appointed by the governor from among nominees chosen from each legislative caucus (Republican and Democratic causes in each house), and two ex-officio nonvoting members: the director of the Health Care Authority and the Insurance Commissioner.
Staff: The state Health Care Authority helped the HBE Board get started by providing staff and other resources; in 2013 HBE had nine leadership staff and 114 full time equivalents.
Major funding: $151 million in federal grants.
Principal contractor, system integration/project management: Deloitte, IBM

(Continued on the Following Page)

Table 2. Exchange Structure in the Western States

IDAHO
Exchange name: Your Health Idaho
Form: Quasigovernmental, clearinghouse. Officially, this is designated as a federally supported exchange, as opposed to a state-federal partnership or a federally facilitated exchange. It will become fully state run in 2014.
Board: Nineteen members appointed by the governor, confirmed by the state Senate.
Staff: At this early stage, one executive director and three directors of major divisions.
Major funding: $20.3 million in federal grants.

Early Starts Contributed Essential Development Time

Many states waited for the Supreme Court decision and the presidential election to make final implementation decisions. That did not allow much time, given the complexities of the ACA. Our out- front states moved more quickly, particularly in three areas.

1. Early political consensus — and consistent political leadership — allowed fast forward movement to develop, test, and learn about state-run exchanges and expanding Medicaid. California, Colorado, Nevada, Oregon, and Washington each benefitted from early decisions described in the state reports.
2. The early framework for implementation accepted the diversity of existing authority, the need for a new quasigovernmental, semi-independent entity to run the insurance exchange, and the need for high levels of coordination, communication, and executive leadership within and across sectors. Each of these states adapted the ACA to the state context. For example, public management of ACA implementation in Washington is spread across four state agencies and the new quasigovernmental independent exchange. We found intermittent concerns over the sometimes highly independent nature of the Health Benefit Exchange and occasional attempts by that agency to "go it alone." The major public management challenge in Washington was coordination. Despite a short timeframe, coordination was achieved through strong facilitation from the Governor's Office and leading state executives.
3. Key players in each of the Western states believed they were working under unrealistic time pressure. A major coping strategy was to accept this reality and develop strategic plans for assessment and reform when "the dust settles" after the first few years of the implementation.

Fiscal Federalism and Western Pragmatism

Much of the West can be viewed as fiscally conservative. California is the home of Proposition 13 and surrounding states have either copied that measure or invented more stringent approaches. Taxing, spending, and debt ceilings are in place in every state and in many municipalities. In this context, the 2008-11 recession amplified public spending limits and made the potential of federal funds for the ACA all the more enticing, despite conservative arguments to avoid the evils of dependency on federal money. In the end, debates about whether to accept federal funds have often ended with comments along the lines of those made by Colorado Governor John Hickenlooper:

> Everyone will have to pay something for health care. Colorado [gets] back way too few of the tax dollars we send to Washington. And so to suddenly say, we're not going to [accept] millions [in] grants to implement an exchange … to help lower costs for individuals and small businesses in Colorado, I think we'd be chumps not to do it.[8]

While there was ample discussion and debate about the implications of accepting ACA funds, Western states in the end were reluctant to reject revenue needed to restore programs, particularly Medicaid. While some Arizona leaders, including Governor Brewer , advocated rejection of Obamacare and the funds that came with it, the state accepted more than $30 million for planning a state-run exchange that never happened; then, after much political drama, they accepted Medicaid expansion funding.

Federalism Spawns Continuous Conflict and Innovation

In American federalism, public policy often develops within a robust mix of intergovernmental conflict and cooperation. The national government regularly cultivates broad domestic programs and legislation while relying on state and local governments and other local organizations to implement those efforts. Bargaining is continuous. State and local governments and organizations accept implementation roles that accompany incentives, though not always enthusiastically and often grudgingly. Some measure of political and policy conflict is almost certain. Representatives and staffs of national and state governments frequently appear leery of each other's motivations, intentions, and abilities.

Despite, and to some degree because of, frequent conflict, implementation of intergovernmental policy requires substantial cooperation, collaboration and coordination, and management beyond political rhetoric, particularly in operational matters. New major policy innovations such as the ACA require substantial collaboration among leaders and staff, and sometimes by people with little or no experience working with each other.

Implementation, Technology, and Learning Governance

In their classic study of a federal war on poverty program in Oakland in the 1970s, Jeffrey Pressman and Aaron Wildavsky generated important conclusions about the obstacles to and complexities of implementation. These conclusions apply to many major national public initiatives, including ACA in 2014.

> The experience of this program, which began with laudable intentions, commitment, and an innovative spirit, shows that *implementation* of a large-scale federal project can be very difficult indeed. Money was duly authorized and appropriated by Congress; the federal agency approved projects and committed funds with admirable speed. But the "technical difficulties" of implementation proved to be more difficult and more time-consuming than the federal donors, local recipients, or enthusiastic observers had ever dreamed they would be.[9]

In October 2013, the ACA ran headlong into this often-encountered flaw of intergovernmental implementation. The ACA was strongly impacted by technical problems of HealthCare.gov, the massive publicity and political gamesmanship associated with those problems, and the resulting effects on enrollment and state-level ACA resources.

State-run exchanges, including those in our Western sample, were not immune to these difficulties. Oregon has had a particularly difficult time with its Web site, which was not functional during most of 2013. This surprised some observers given that state's longstanding commitment to health care reform, its early start on building the exchange, and significant federal resources devoted to what some describe as visionary health reform.

Other fully aligned Western states also had problems with their exchanges and Web sites in October. California, Colorado, and Washington each experienced brief periods of technical failure despite relatively early starts and significant resources devoted to building their sites. Yet these state-run exchanges recovered quickly, allowing them to continue progress toward enrollment goals. Washington Associate Aaron Katz suggests what may be most surprising is the level of success these Western states have had in the face of huge obstacles: limited time and money, unreasonable expectations, technical complexity, and well-organized and active opposition. The history of state agency data systems gone awry is long, and the recent history of problematic federal IT projects is one of almost continuous crisis management.[10]

What accounts for this early measure of public management resilience among the leading Western states? What are the future implications of their efforts on state ACA development and the building of effective exchange Web sites? The month of October was insufficient time to determine precisely what went right and what went wrong in each case and pinpoint best measures of recovery. Yet we have clues from the field.

In general, Western states moved quickly to establish quasigovernmental, relatively independent exchanges. These exchanges were well funded by federal planning grants, and a large portion of the money was targeted to IT development. In each state, exchange boards and staff saw IT development as the absolute highest priority. Contractors with significant IT expertise were hired to develop exchange sites. Staff in Washington, California, and Colorado expressed concern that despite this substantial effort and the priority given to IT development, the merging of disparate intergovernmental systems and data and the limited time for building, testing and implementation would almost certainly result in some problems and necessary predictable fixes when the exchanges went live in October. This context would strain the feedback loop anywhere, although there were major differences in the magnitude of IT issues and state responses.

States such as Washington, California, and Colorado that charted a smoother course built simpler sites and did not attempt to create the ultimate system from scratch. Each of these states planned to add to these systems incrementally. That is, these states planned to use "learning governance" to allow time for repeated testing, repair, and redesign. As mentioned above, Oregon, on the other hand, may have attempted to do too much with its initial system design.

Ultimately, the technical implementation progress of several Western states, although incomplete, is a function of planning to learn from web development, moving ahead on a steady professional basis, getting beyond political battles that each state faced early on, and placing public management and governmental competence ahead of political debates. Such essential pillars of public management as oversight and accountability are particularly challenging in quasi-independent arrangements like many of the state exchanges and specialized Medicaid departments. Public oversight and management is especially daunting given the need to manage advanced technologies and the centrality of IT to the exchange mission.

Our affirming Western states appear to have established the necessary independence, experience, and time to craft reasonably effective feedback and oversight. As a group, these states have had strong public leadership and coordination. They are deploying teams of skilled professionals on boards and in high-level staff positions to interact with the systems designers as well as each other and counterparts in other states. These states have done more testing followed by needed interventions. They have issued clear and objective descriptions of problems and fixes, and of course have had the advantage of some degree of political cover, including agreement over needed health reforms and requisite focus on long-term capacity building and problem solving.

The Future

Compared to many other states, this cluster of Western states is off to a fast start in the implementation of the ACA. Yet questions remain. Will the quick start and alignment with the goals of the ACA be sustainable? Will Western states develop and meet higher performance standards leading to desired health outcomes and more complete development of affordable care? The challenge is achieving full reform of the American health care system through intergovernmental cooperation. As one observer put it, "You know what's relatively easy? Fixing a Web site. You know what's really hard? Ensuring access to affordable, quality health care for every single American and improving our broken health system in the process."[11]

Operational Versus Rhetorical Federalism

It is still quite early in the history of ACA-stimulated health care reform and there are many obstacles to overcome. It is possible that a mix of political challenges, bad publicity, unmet expectations, and general public dissatisfaction could derail, dilute, or even ultimately defeat the ACA. That scenario is one potential outcome of rhetorical federalism.

Our Western state sample, however, seems pointed in another direction. The majority of these states have adopted structures and changed institutions and rules to enable development of state health reforms that complement those of the ACA. These states are aligned with the national ACA policy in the following ways:

- Created largely independent exchanges governed by diverse, highly qualified state boards.
- Recruited and deployed diverse, talented staff to design state health care reform.
- Began building virtual state health insurance exchanges by linking public and private interests and data with increasing success.
- Trained and developed large outreach efforts to canvass states and facilitate expansion of health insurance for all qualified residents.
- Expanded Medicaid.
- Passed legislation to aid in funding these efforts following federal grants.

This capacity, in place and being augmented now, is operational federalism. Western states are in front because they were already on the path to health care reform. They are likely to push ahead just as they did with universal public education in the last century. In the West it appears, at least for now, that the health care reform train has left the station.

Endnotes

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