Report on Health Reform Implementation

Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma

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Editor's Note: Thanks to funding from the Blue Shield of California Foundation and the Robert Wood Johnson Foundation, JHPPL *has begun the coordination of an Engaged State Health Reform Research Network to bring together people from different backgrounds (practitioners, stakeholders, and researchers) involved in state-level health reform implementation to inform and extend health reform across the United States. A network website will document implementation projects across the country, workshops will be held, and* JHPPL *will publish essays under this new section based on findings emerging from network participants. All essays in the section will be published open access.*
—Colleen M. Grogan

Abstract Enactment of the Patient Protection and Affordable Care Act (ACA) created a dilemma for Republican policy makers at the state level. States could maximize control over decision making and avoid federal intervention by establishing their own health insurance exchanges. Yet GOP leaders feared that creating exchanges would entrench a law they intensely opposed and undermine legal challenges to the ACA. Republicans' calculations were further complicated by uncertainty over the Supreme Court's ruling on the ACA's constitutionality and the outcome of the November 2012 elections. In the first year of operation, only seventeen states and the District of Columbia chose to design and implement their own exchanges; another six partnered with the federal government, and twenty-seven states ceded control to Washington. Out of thirty states with Republican governors in 2013, only four launched their own

The authors gratefully acknowledge the research assistance of Alex Bernard, Alex Coburn, Sahil Gosain, Hannah Mesa, and Phillip Singer.

Journal of Health Politics, Policy and Law, Vol. 39, No. 1, February 2014
DOI 10.1215/03616878-2395190

exchange. Why did many Republican-led states that initially appeared open to establishing exchanges ultimately reverse course? Drawing on interviews with state policy makers and secondary data, we trace the evolution of Republican responses to the exchange dilemma during 2010–13. We explore how exchanges became controversial and explain why so few Republican-led states opted for their own exchange, focusing on the intensifying resistance to Obamacare amid a rightward shift in state politics, partisan polarization, and uncertainty over the ACA's fate.

The 2010 Patient Protection and Affordable Care Act (ACA) transforms the balance of power between states and the federal government in health policy making. The law expands the federal government's authority to regulate the health insurance industry and requires most Americans to obtain and larger businesses to offer insurance or pay penalties. It also aims to create national Medicaid eligibility standards for adults far beyond the levels that exist in most states. At the same time, the ACA confers a significant role on states by granting them the power to establish health insurance exchanges (Greer 2011; Jennings and Hayes 2010; Sparer 2011). States must also tackle a host of other responsibilities, including reviewing health insurance premium increases and enforcing new insurance market regulations (Keith, Lucia, and Corlette 2013; Sommers and Epstein 2010; Thompson 2011). And they must decide whether to expand their Medicaid programs to meet the ACA's new eligibility standards. States have not grappled with health reform on such a large scale since Medicaid's enactment in 1965, and the ACA arguably presents a more daunting task—particularly for the states implementing a Medicaid expansion and establishing their own exchange.

The political environment for implementing reform has also been challenging. The 2009–10 health care debate was highly partisan—Congress passed the ACA in its final form without any Republican votes in the House or Senate. No sooner had the ACA passed than Republicans launched a campaign to "repeal and replace" the law. Opposition to "Obamacare" has been widespread among state Republican leaders and engendered a robust nullification movement (Leonard 2011). Twenty-six states joined a lawsuit challenging the ACA's constitutionality, Virginia pursued an independent lawsuit, and nineteen states passed legislation or adopted resolutions opposing elements of the law (NCSL 2013). The fierce state resistance to the ACA is unusual, since "sustained formal state legislative and legal challenges to federal regulation have been extremely rare" in recent decades (Shelly 2008: 444). The partisan nature of the resistance to health reform, in response to a major federal law enacted on

partisan lines, makes this an even more exceptional case in American political history.[1]

Yet health insurance exchanges were one ACA provision that could have been expected to elude this controversy and attract bipartisan support. Republicans have a history of supporting the establishment of purchasing pools, which are broadly consistent with their thinking on health reform. Exchanges—regulated marketplaces in which the uninsured and small businesses can buy coverage—embody ideas of choice and competition and rely on private insurance. The ACA, by enabling states to establish their own insurance pools rather than creating one national exchange, gave states the flexibility to determine their structure, governance, and level of regulation. In so doing, the ACA embraced the oft-cited (and criticized) case for federalism, one frequently invoked by Republicans in the name of devolution: pervasive regional differences in political ideology, economics, culture, and health systems mitigate against "one-size-fits-all" solutions imposed by Washington; states are more attentive and responsive to their citizens' needs; and states can serve as laboratories of democracy that illuminate the virtues and vices of different policy approaches (Conlan 1998; Leichter 1996, 1997; Peterson 1995; Sparer and Brown 1996; Thompson and Diulio 1998).

Nonetheless, exchanges created acute political, legal, and administrative dilemmas for Republicans. By establishing exchanges, Republican governors and legislators risked undermining state lawsuits against the ACA and being seen as Obamacare collaborators by conservative voters and activists. Moreover, if states made insufficient progress on setting up insurance exchanges, the ACA authorized the federal government to do it for them. State resistance to the ACA would, then, paradoxically lead to greater federal intervention in resisting states. Republicans' calculations were further complicated by uncertainty over the Supreme Court's ruling on the ACA's constitutionality and the outcome of the November 2012 elections.

The dilemma that Republican policy makers confronted regarding exchanges was, as an insurance department official in a conservative state told us, reminiscent of Pascal's Wager. Facing uncertainty over whether God exists, seventeenth-century French philosopher Blaise Pascal ([1669] 1995) concluded that the safest way to live is by assuming that God is real and a judgment waits in the afterlife. Similarly, Republicans' responses to

1. We thank David Mayhew for this point. Shelly (2008) identifies No Child Left Behind as another recent case of state resistance, though he does not find any partisan pattern to state responses to that legislation.

the exchange dilemma hinged in part on whether they believed the ACA would survive legal and political challenges. Some GOP policy makers believed the prudent approach was to hedge their bets by assuming that the law would stand and its deadlines would be enforced. Others doubled down on the idea that they could alter the law's fate by treating it as if it did not exist.

How did Republican state leaders respond to the insurance exchange dilemma? Why did many Republican-led states that initially appeared open to establishing exchanges ultimately reverse course? And what explains the shifting Republican responses to exchanges over time—from receptiveness and hedging bets to reversals and ultimately rejection—as well as varying responses across Republican-governed states?

We address these questions by drawing on interviews—conducted between June 2011 and February 2013—with more than ninety officials in the legislative and executive branches of twenty-four states, including advisers to governors, state legislators and their staffs, consultants, and bureaucrats at state departments of insurance and health. Additional interviews were conducted with congressional staffers and stakeholder groups. We also utilize state legislative roll call data, primary documents, and other secondary sources.

The article begins by reviewing the history, development, and politics of exchanges and by tracing their emergence in the ACA. Next, we explore state responses to the ACA's exchange provision and chart how those responses shifted, both within and across states, over four time periods. We then explain why exchanges became so controversial and why few Republican-governed states ultimately opted for a state-run exchange. We conclude by commenting on the future of exchanges and examining broader implications for health reform implementation.

The Origins and Development of Health Insurance Exchanges

The idea that small businesses and the uninsured should buy insurance coverage through organized purchasing pools has pervaded American health policy for at least two decades. In the early 1990s, Alain Enthoven (1993) called for creating health insurance purchasing cooperatives to promote managed competition. President Bill Clinton's Health Security Act, influenced by Enthoven's model, sought to establish health alliances through which most Americans would obtain coverage. The Clinton administration struggled to explain to the public the role of alliances and

the benefits of managed competition. After the Clinton plan's demise, the idea lived on, as policy analysts continued to propose similar institutions—albeit without the stigmatized "alliance" label—as a cornerstone of reform (Meyer and Wicks 2003). Meanwhile, small-business purchasing pools—commonly known as health insurance purchasing cooperatives—emerged in a handful of states during the 1990s, including California, Texas, and Florida, though they produced mixed results and in some cases did not survive (Long and Marquis 2001; Wicks 2002). Then, in 2006, as part of its landmark reform law, Massachusetts established a health insurance "Connector"—open to the uninsured and smaller firms—raising the profile of purchasing pools in the national health care debate (McDonough 2011). The major Democratic candidates in the 2008 presidential campaign embraced such pools as a central feature of their health care plans (Hacker 2008a). And in 2009 Utah opened its own health insurance exchange focused on small employers.

The precise role and scope proposed for these institutions have changed over time and varied considerably by plan. The Clinton administration envisioned alliances as the central insurance hub for most Americans, while the ACA's exchanges have a more limited role as a residual means to cover the uninsured—a scaling down that reflects lessons the Obama administration learned from the Clinton reform misadventure about the political perils of alienating insured Americans (Oberlander 2010).

But the primary rationale for such reforms—leveraging the advantages of broader risk pooling—has remained consistent. The uninsured lack purchasing power in the nongroup health insurance market, where they face discrimination based on health status and higher administrative costs. Similar problems confront small businesses buying coverage on the small-group market (Jost 2012; Kingsdale 2012). If individuals in these groups can be pooled in larger numbers into a regulated insurance market, then risk can be spread more broadly and they should gain access to more affordable coverage. Administrative costs should decline as larger scales are achieved and the costs of marketing, underwriting, and other expenses drop (Blumberg and Pollitz 2009; Cutler, Davis, and Stremikis 2010; Kingsdale 2010). In other words, purchasing pools aim to bring efficiencies of the large-group market to small businesses and the uninsured. Advocates also contend that purchasing pools can enhance choice of health plans, ensure greater transparency, and save money by promoting cost-conscious consumer decisions and price competition among insurers (Enthoven 1993; Kingsdale 2010).

Purchasing pools have drawn support from Republican-allied stakeholder groups, including small-business associations seeking better health care options for their members and private insurers enticed by the prospect of expanding markets. Not surprisingly, given the emphasis on choice, competition, and consumerism, as well as the reliance on private insurance, such pools have also attracted conservative policy analysts and Republicans seeking market-friendly policies to expand insurance coverage and control health spending. A 1993 Republican alternative to the Clinton health plan sponsored by Rhode Island senator John Chafee, the Health Equity and Access Reform Today Act (HEART), proposed creating new individual and small employer purchasing groups whose establishment and operation were to be regulated by the states (Quadagno, this issue).[2] The Massachusetts Connector, adopted by the state in 2006, derived from a Heritage Foundation proposal (McDonough et al. 2006). After the Massachusetts law passed, Heritage research fellow Edmund Haislmaier (2006) praised the Connector for advancing "consumer choice of plans and true coverage portability." He argued that "governors and legislators would be well advised to consider this basic model as a framework for health care reform in their own states." Even during the intensely partisan debate over the ACA, purchasing pools remained a GOP favorite. A major Republican alternative to the ACA—the 2009 Patients' Choice Act, co-sponsored by Senator Tom Coburn (Oklahoma) and Congressman Paul Ryan (Wisconsin), subsequently the 2012 Republican nominee for vice president—proposed creating state exchanges that would provide a "one-stop marketplace for health insurance" (Ryan 2009).

During the 2000s, liberal analysts and Democratic politicians increasingly embraced purchasing pools as a desirable and politically feasible strategy to cover the uninsured (Meyer and Wicks 2003). Exchanges have remained a crucial component in health reform models since the 1990s largely because they offer a way to expand coverage while preserving private insurance—widely seen as the only viable path that reform legislation can take through Congress (Hacker 2008a). Exchanges, in fact, draw political strength from a flexible identity: while their consumer choice dimension appeals to the Right, their promise to regulate health insurers appeals to the Left. They also promise to improve coverage for both uninsured individuals and small businesses, augmenting their ability to resonate with reformers of different ideological stripes and diversifying

2. Exchanges are not the only part of the ACA with early Republican support that subsequently evaporated. The individual mandate, also part of the HEART legislation, had a political trajectory that in some respects mirrors that of the exchanges (Quadagno, this issue).

their political constituency. A conservative means to a liberal end, purchasing pools consequently provide a vehicle to expand coverage that potentially has broad, bipartisan political appeal. That potential is evident in polling data. In a June 2010 Kaiser Family Foundation survey, 87 percent of all respondents—including 77 percent of Republicans—said they had a very or somewhat favorable opinion of exchanges, the highest level of support for any feature of the ACA (KFF 2010).

The 2006 Massachusetts reform law appeared to confirm the political logic of purchasing pools. Health reform legislation in Massachusetts enjoyed strong bipartisan support from Democrats, the state's Republican governor (Mitt Romney), and GOP legislators. The law—which strengthened existing insurance market reforms and established income-related subsidies, an individual mandate to purchase coverage, penalties for employers not offering coverage, and a new insurance purchasing pool—passed the state House and Senate by a nearly unanimous vote (McDonough et al. 2006). Massachusetts thus provided Democrats with both policy and political blueprints for passing health reform, since its enactment suggested that national health reform could be realized if Congress and the president emulated the state's successful formula (McDonough 2011; Oberlander 2010; Starr 2011).

The ACA and Health Insurance Exchanges

The three top-tier Democratic candidates in the 2008 presidential primary—Hillary Clinton, John Edwards, and Barack Obama—all offered variants on the Massachusetts model. Democrats, though, made one important addition to the purchasing pools: a Medicare-like government health plan for Americans under age sixty-five. For liberals, the public option ensured that the uninsured could choose to join a nonprofit insurance program that would not discriminate against sicker enrollees. Advocates also viewed the public option as the key to controlling spending: its lower administrative costs and greater purchasing power would produce savings and force private insurers to lower premiums or lose market share (Hacker 2008b, 2009). Moreover, the presence of a public plan could promote competition in states where small numbers of insurers dominate the nongroup market (Holahan and Blumberg 2009).

After the 2008 elections, exchanges remained a foundation of Democrats' health reform plans. But while the House passed legislation authorizing the federal government to operate a national insurance exchange that contained a public option, the Senate bill gave states responsibility for

establishing and regulating the new insurance marketplaces, with the federal government stepping in only if states chose not to set up an exchange. The Senate bill reflected the decentralizing preferences of conservative Democrats like Ben Nelson of Nebraska and the need to mobilize all sixty Democrats to overcome a Republican filibuster.

Liberals who favored the House bill argued that states could not be trusted to enforce insurance regulation or implement federal law and that a national exchange would create a more efficient and fair system—though the House bill did permit states to establish their own exchanges if they satisfied federal requirements (Abelson 2010; Jost 2010). Conservatives countered that the national exchange concentrated too much power in Washington at the expense of states. Nelson warned that "the national exchange is unnecessary and I wouldn't support something that would start us down the road of federal regulation of insurance and a single-payer plan" (Budoff Brown 2010).

Meanwhile, liberals saw a national exchange as an even more important goal after it became clear that a bill including a public option could not clear the Senate. In negotiations between the two chambers to combine their respective bills, President Obama initially supported the House vision of a national exchange (Werner 2010). However, Ted Kennedy's death and Scott Brown's surprise victory in the Massachusetts special election cost Democrats their filibuster-proof majority in the Senate, upending Democrats' intraparty negotiations and forcing them to fashion a new process to enact the law. That ultimately led to the House passing the Senate bill and then to both chambers enacting a reconciliation "sidecar" that included a limited number of changes. The Senate version of exchanges thereby prevailed in the ACA, giving states the chance to take the lead in their implementation.

Reformers had compelling political reasons, then, to promote federalism by empowering state exchanges. Absent a significant role for the states, the ACA would not have passed Congress. But as Paul Starr (2011: 2) notes, reformers had won "an uneasy victory," since the ACA's "implementation was left in large measure to governors and legislatures" committed to overturning Obamacare.

State Responses to Health Insurance Exchanges

State exchanges will play a prominent role in the reformed health care system. Seventeen states and the District of Columbia have opted to run their own exchanges, and another six are partnering with the federal

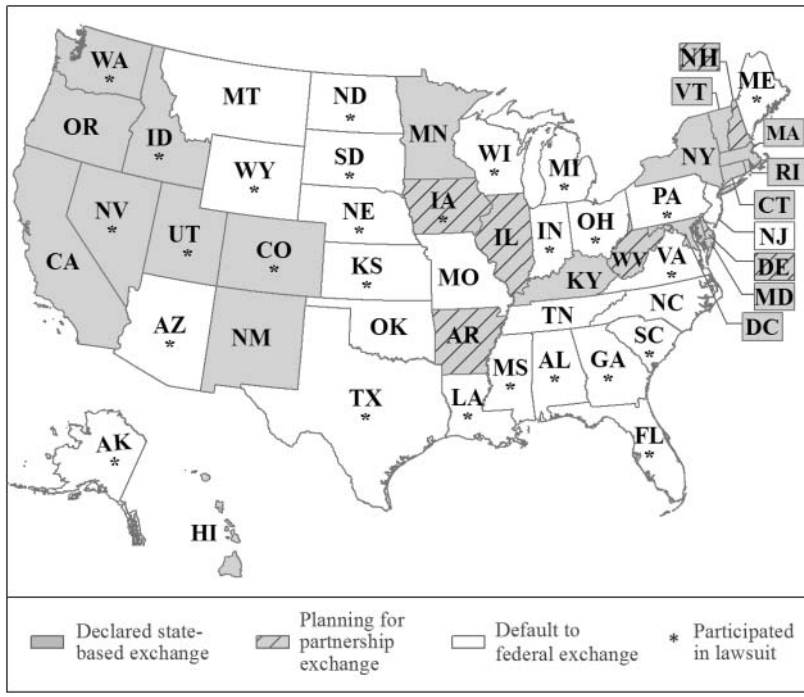

Figure 1 State Exchange Decisions as of April 1, 2013

Sources: Dash, Monahan, and Lucia 2013; KFF 2013

Notes: Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia opted to retain control of plan management functions in a de facto partnership with the federal government. Utah opted to create a state-run purchasing pool for small businesses, while the federal government will operate the exchange for the individual insurance market.

government. The remaining twenty-seven states are ceding establishment and operation of exchanges to Washington (fig. 1). The Congressional Budget Office (2013) estimates that by 2016, 24 million Americans will obtain coverage through the exchanges, navigating online portals to choose from a menu of private health plans offering four different coverage levels. Exchanges will cover both uninsured individuals and persons working for small businesses that choose to join them. Exchanges are also the mechanism by which qualifying individuals will receive insurance subsidies. However, most Americans with employer-sponsored coverage will be ineligible to receive subsidies to buy insurance on the exchanges. Initially, firms' access to exchanges will be limited to companies with fewer than one hundred workers, though after 2016 they can be opened up

more broadly. Enrollment will start in the fall of 2013, and the exchanges are expected to be financially self-sustaining beginning in 2015.

States choosing to create an exchange have faced at least five initial policy design decisions. First, they could set up a single statewide exchange, run multiple exchanges for different parts of their state, or create a multistate partnership. Second, states had to decide how aggressively to regulate their exchanges, either choosing a clearinghouse model in which any plan meeting minimal requirements is allowed to participate, or an "active purchaser" model in which only plans meeting a higher standard are allowed to participate. Third, an exchange could be designed as a nonprofit corporation, a state entity, or a quasi-governmental organization. Fourth, states had to make decisions about governance, including whether to allow brokers and representatives of insurance companies to serve on the boards of directors. Fifth, states could set up separate exchanges for the nongroup (individual) and small-group (business) markets, or develop one combined exchange.

Before grappling with design issues, states first had to decide whether to establish an exchange at all. For those moving forward, the decision-making process was largely driven by the time line of four federal grants: (1) a planning grant of approximately $1 million received on September 30, 2010, by every state except Alaska and Minnesota;[3] (2) an innovator grant ranging from $6 million to $54.5 million received by eleven states in February 2011, including a consortium of New England states administered by the University of Massachusetts (this grant aims to fund the development of IT infrastructure for exchanges and promote the sharing of IT models with other states); (3) level 1 establishment grants available on a quarterly basis and received by thirty-six states and the District of Columbia as of February 2013, at an average of about $37 million; and (4) a level 2 establishment grant intended to carry exchanges to 2015, when they are to be self-sustaining. As of February 2013, twelve states had received level 2 grants averaging $166 million per state. The final deadline for the level 2 grant initially was June 29, 2012, though the federal government subsequently extended this deadline to October 15, 2014. As table 1 shows, many millions of dollars in planning, level 1, and level 2 grants were awarded to states that ultimately decided not to pursue implementation of state-based exchanges, although some of these grants were later returned.

State responses to exchanges reflected, in part, the broader partisan politics of the ACA. In the three years after the ACA's passage in March

3. After Mark Dayton (D-MN) replaced Tim Pawlenty (R-MN) as governor in January 2011, Minnesota applied for and received a $1 million planning grant.

Table 1 Federal Exchange Grants Awarded by Type of Exchange

Exchange Type	No Grant	Planning but No Levels 1 and 2	Planning and Level 1	Planning and Levels 1 and 2
State			CO, HI, ID, MN, NM, UT	CA, CT, DC, KY, MA, MD, NV, NY, OR, RI, VT, WA
Partnership			AR, DE, IL, IA, MI, NH, WV	
Federal	AK	FL, GA, KS, LA, MT, ND, OH, OK, SC, TX, WI, WY	AL, AZ, IN, ME, MS, MO, NE, NJ, NC, PA, SD, TN, VA	

Source: Healthcare.gov
Note: Information current as of March 2013

2010, floor votes were held on twenty-seven bills in at least one chamber of twenty-two states (see table 2).[4] In these states, 88 percent of Democratic legislators voted in favor of legislation creating an exchange, while 42 percent of Republican legislators voted for such bills. More than sixty bills to establish an exchange were introduced in other states but never received a floor vote (CBPP 2013).

Four Republican governors presided over the creation of an exchange: three with Democratic majorities in their state legislatures (California, New Mexico, and Nevada) and one with unified Republican control (Idaho). Two other Republican-governed states—Massachusetts (with a Democratic legislature) and Utah (with a Republican legislature)—established purchasing pools prior to the ACA's enactment (table 3). Two Republican governors vetoed enabling legislation passed by Democratic legislatures (Chris Christie in New Jersey and Susana Martinez in New Mexico, though Martinez later signed a different exchange bill), while Democratic governors in two states (Montana and Missouri) vetoed legislation passed by Republican legislatures that would have prohibited the creation of an exchange.

As the roll call data reveal, Republicans were hardly unanimous in their opposition to exchanges. Indeed, nine of the seventeen states that eventually decided to operate state-based exchanges had either a GOP governor or a Republican majority in at least one house of the legislature when the

4. Democrats had majorities in twenty-eight of forty-four legislative chambers in these states and shared control of the Oregon House with Republicans.

Table 2 Roll Call of Floor Votes on Legislation to Create Exchanges, Pre- and Post-ACA

Pre-ACA

State	Date	Legislature (upper-lower)	Bill	Status	% R	% D
MA	Apr. 2006	D-D	Ch. 58	Enacted	91.3%	100.0%
UT	Mar. 2009	R-R	HB 188	Enacted	93.9%	96.3%
				Total	92.6%	98.1%

Post-ACA

State	Date	Legislature (upper-lower)	Bill	Status	% R	% D
CA[a]	Sept. 2010	D-D	SB 900	Enacted	2.4%	94.6%
CA[a]	Sept. 2010	D-D	AB 1602	Enacted	4.8%	93.2%
MS[b]	Mar. 2011	D-R	HB 1220	Passed, not law	59.8%	91.1%
WV	Apr. 2011	D-D	SB 408	Enacted	0.0%	97.8%
RI	Apr. 2011	D-D	SB 87	Passed, not law	85.7%	80.0%
NM	Apr. 2011	D-D	SB 38	Vetoed	21.3%	92.3%
MD	Apr. 2011	D-D	HB 166	Enacted	41.1%	94.7%
MO	Apr. 2011	R-R	SB 609	Passed House	97.2%	96.4%
VA[c]	Apr. 2011	D-R	HB 2434	Enacted	92.0%	35.6%
WA	May 2011	D-D	SB 5445	Enacted	33.8%	97.6%
NC	May 2011	R-R	HB 115	Passed House	95.6%	34.6%
VT	May 2011	D-D	HB 202	Enacted	0.0%	90.4%
CO	June 2011	D-R	SB 11-200	Enacted	27.1%	98.1%
NJ	June 2011	D-D	A 1930	Passed Assembly	0.0%	80.8%
NV	June 2011	D-D	SB 440	Enacted	88.9%	97.2%
OR	June 2011	D-S[d]	SB 99	Enacted	63.6%	95.7%
CT	July 2011	D-D	SB 921	Enacted	25.8%	94.2%
HI	July 2011	D-D	SB 1348	Enacted	89.0%	100.0%
ND	Nov. 2011	R-R	HB 1474	Failed House	14.5%	87.0%
MI	Nov. 2011	R-R	SB 693	Passed Senate	50.0%	100.0%
AL	Apr. 2012	R-R	HB 245	Passed House	92.4%	79.5%
NJ	May 2012	D-D	A 2171/ S 1319	Vetoed	0.0%	87.5%
NJ	Dec. 2012	D-D	A3186/ S2135	Vetoed	0.0%	89.0%
NM	Feb. 2013	D-D	HB 168	Failed House	0.0%	79.0%

Table 2 (*continued*)

Post-ACA

State	Date	Legislature (upper-lower)	Bill	Status	% R	% D
MN	Mar. 2013	D-D	HF 5	Enacted	3.0%	96.0%
NM	Mar. 2013	D-D	SB 221	Enacted	96.0%	84.0%
ID	Mar. 2013	R-R	HB 248	Enacted	53.0%	95.0%
				Total	42.1%	87.5%

Source: Official website of each state legislature
Note: Information current as of March 2013
[a] Two companion bills were enacted the same day.
[b] Bill did not make it through a conference committee.
[c] Bill states intent to create an exchange, but does not authorize any particular action.
[d] The *S* indicates that control of the Oregon House was split between Republicans and Democrats.

decision was made. And among the states electing to partner with the federal government, three were either led by a Republican governor or had a Republican majority in at least one chamber of the legislature. Of the seven states that chose to retain control of plan management within an otherwise federally run exchange, six were led by Republican governors. Strikingly, the only state with a Republican governor and Republican-controlled legislature that chose to create its own exchange—Idaho—is by at least one measure the most conservative state in the country (Shor and McCarty 2011).

Substantial variation in Republican response existed even among the states that joined the lawsuit challenging the ACA's constitutionality. By the time the Supreme Court issued its June 2012 decision upholding the ACA, those states had applied for more than $300 million in grant money to support the creation of exchanges. Moreover, while no Republicans voted for exchange legislation in New Jersey, Vermont, and West Virginia, approximately 90 percent of Republican legislators in Nevada and Hawaii voted to establish exchanges, as did more than 90 percent of Republicans in the lower chambers of the Alabama, Missouri, and North Carolina legislatures. Typifying the changing politics of health reform, overwhelming Republican majorities in Massachusetts (2006) and Utah (2009) voted to create purchasing pools prior to the ACA's enactment. If we count only post-ACA votes in states where legislators in at least one chamber voted, 42 percent of Republicans voted for exchanges through February 2013, compared with an average of 93 percent in the two states with votes prior to

Table 3 Party Control of States Creating Insurance Exchanges

	Unified Democrat	Unified Republican	Mixed Party Control
Created legislatively	CT, HI, MD, MN, OR, WA, VT	ID, UT	CA, CO, MA, NM, NV
Created by executive order			KY, NY, RI

Source: www.statehealthfacts.org
Note: Information current as of March 2013; party control coded at the moment of authorization.

the ACA. Exchange bills were not identical across states, though, and it is thus difficult to draw definitive conclusions by comparing roll call votes. For example, in states such as New Mexico, Democrats resisted supporting exchange proposals that they believed were overly solicitous of the insurance industry. Still, these votes underscore the divisions among Republicans and show how the debate over exchanges became more polarized along partisan lines after the ACA's enactment. Ultimately, out of thirty states led by Republican governors in 2013, only four established a state-run exchange.

Given the conservative roots of insurance exchanges and the prospect of federal intervention, why did so many state Republican leaders oppose state-based exchanges? After all, insurance exchanges drew relatively little fire from Republicans during the 2009–10 health reform debate. Moreover, prominent GOP leaders supported the concept even as they fought for the ACA's repeal. Senator Coburn (R-OK) (2011), for example, continued to back "state-based efforts to create free-market, voluntary health insurance exchanges," though he distinguished them from the ACA's ostensibly more onerous exchanges. And exchanges remained popular with Republican voters: though support for exchanges was lower than it had been two years prior, 62 percent of self-identified Republicans had very or somewhat favorable opinions of exchanges in a December 2011 poll (KFF 2011). Nonetheless, as the next section shows, Republican resistance to exchanges intensified over time with significant inter- and intrastate variation.

Evolving Republican Reactions

State responses to health insurance exchanges evolved over four distinct periods between the time that President Obama signed the ACA into law in March 2010 and the February 2013 deadline by which states had to declare their intentions to pursue state-run or partnership exchanges. Initially,

many Republicans pursued legal and legislative challenges to Obamacare while also moving ahead with exchange planning (March 2010–December 2010). But after the rightward shift in state legislatures following the 2010 elections, resistance emerged (January 2011–October 2011) as a number of Republican-led states reversed their previous support for exchanges. Still, other GOP-led states embraced the concept. State Republican leaders had to decide whether to take Pascal's Wager—that is, whether to bet on the ACA's survival and pursue state planning for an exchange, even if they opposed Obamacare. The Supreme Court case on the ACA's constitutionality and impending exchange deadlines dominated the third period (November 2011–June 2012) as resistance further hardened in some GOP-led states. The final period—July 2012 to March 2013—encompassed reactions to the Supreme Court ruling upholding the ACA and to President Obama's reelection, as states that had held out were finally forced to make decisions regarding exchanges. In this section we discuss the choices made by Republicans in each of these periods, highlighting illustrative cases and the shifting politics of exchanges.

March 2010–December 2010: Hedging Bets

Most Republican-led states initially responded to the ACA's enactment by simultaneously opposing it and laying the foundation for its implementation. At first health insurance exchanges were not controversial. Every state except Alaska and Minnesota applied for and received an exchange planning grant of approximately $1 million (table 1), including all twenty states that joined the lawsuit in 2010 and the other six states that later joined the lawsuit in 2011. California became the first state after the ACA to pass legislation establishing an exchange, with Republican governor Arnold Schwarzenegger signing a pair of authorizing bills despite the opposition of Anthem Blue Cross and the state chamber of commerce. Schwarzenegger had previously offered his own Massachusetts-style health reform plan in 2007 and had endorsed the ACA. On signing the California exchange laws, the governor noted that after the 2007 plan had failed to pass the legislature, "we said, we'll be back" (Jewett 2010).

But as California was moving to implement exchanges and other states were accepting planning grants, many were also joining efforts to overturn the ACA. Republican leaders in thirteen states filed a joint lawsuit challenging the ACA's constitutionality on the very day that President Obama signed the bill into law. Within two months, seven more states joined the lawsuit focused on the constitutionality of the ACA's individual mandate

and Medicaid expansion. Ballot initiatives and constitutional amendments prohibiting a state-based exchange or "mandatory participation in any health care system" passed in Alabama, Missouri, Montana, Ohio, Oklahoma, and Wyoming (NCSL 2013). Opposition to the individual mandate, which united state Republicans, thus overshadowed support for exchanges.

Running against Obamacare proved to be a successful strategy for the Republican Party in 2010, contributing to a major shift to the right across the country during the November elections (Nyhan et al. 2012). Republicans made extraordinary gains and reclaimed a majority in the US House of Representatives while significantly narrowing the Democrats' margin in the Senate. Republicans also performed well at the state level. The GOP enjoyed a net gain of six governors, twelve lower houses, and seven upper houses. Outgoing Democratic governors realized that the dramatic shift to the right in their states would have important consequences for the ACA's implementation. The deadline for major grants in late December 2010 gave them an opportunity to attempt to commit incoming Republican governors to following through on state exchanges. For example, outgoing Democratic administrations in Kansas, Oklahoma, and Wisconsin each applied for exchange innovator grants averaging approximately $30 million.

In sum, though virtually all states initially received planning grants and there were few signs of opposition to exchange implementation, the growing legal challenge to the ACA and Republican gains in the 2010 elections signaled that conflict loomed ahead.

January 2011–November 2011: Republican Reversals

The 2010 elections altered the political landscape. In 2011, twenty-nine states had Republican governors (in addition to a Republican-turned-Independent governor in Rhode Island), and twenty-one had unified governments, with the GOP also controlling both legislative chambers. Republicans enjoyed strong majorities in the chambers they controlled, with an average margin of thirty-three in lower houses and thirteen in upper houses (NCSL 2011).

As new Republican governors took office in January 2011 and other Republicans prepared for legislative sessions, they faced the choice of whether to halt exchange planning altogether or continue laying a foundation in case the law survived. Even as most states followed through on the $1 million planning grant, the total number of states suing over the ACA grew to twenty-six, and twelve states considered constitutional amendments prohibiting the individual mandate. More than two hundred bills and

resolutions opposing the ACA were filed during this period, and such bills were passed in at least a dozen states (NCSL 2011).

Amid the deepening opposition to the ACA and changed political environment, Republicans began to target exchanges. In February 2011, twenty-one GOP governors sent a letter to Secretary of Health and Human Services Kathleen Sebelius arguing that "the system proposed by the PPACA . . . will ultimately destroy the private insurance market." The governors asked the federal government to waive a variety of ACA rules relating to exchanges and provide states with "complete flexibility" to operate the purchasing pools. They warned that if the federal government did not accommodate these requests, then "HHS should begin making plans to run exchanges under its own auspices" (Kaiser Health News 2011). Indiana governor Mitch Daniels, a signatory to the letter, contended that the ACA "expects to conscript the states as its agents in its takeover of health care" (Daniels 2011a). By the fall of 2011, six Republican-led states had returned nearly $100 million in exchange grants.

At the same time, Republican governors such as Rick Snyder (MI) and Sam Brownback (KS) pursued exchange implementation in the face of legislative opposition, albeit with varying degrees of enthusiasm. Some made quiet progress or let state agencies continue planning while governors themselves publicly disavowed the ACA. An adviser to a Republican governor in a western state, capturing the logic of Pascal's Wager, noted that while "the lawsuit is basically a lottery ticket by which everything goes away," the state still needed to make progress on the exchange in order to maintain autonomy if the ACA survived. By November 2011, thirteen Republican-led states had accepted $194 million in establishment grants to create exchanges (Healthcare.gov 2011). In other words, Republicans across the country were moving in separate directions on the question of whether to create state-run exchanges.

The story of exchange planning and resistance in Kansas illustrates political dynamics in backpedaling states, including the intraparty divisions that often arose as the exchange debate unfolded. Before the federal Department of Health and Human Services (HHS) would award an innovator grant to Kansas, it wanted a statement of commitment from newly elected Republican governor Sam Brownback. As a US senator the year before, Brownback had been a vocal critic of the ACA and had voted against it. As governor he continued to speak out against the ACA and supported the new Kansas attorney general's participation in the anti-ACA lawsuit. Yet on February 11, 2011, Brownback wrote a letter confirming his intention to allow the Kansas Department of Insurance to administer

ACA-related grants received from HHS. He described this as part of his "plan for Kansas to provide efficient management, coordination and appropriate oversight consistent with Kansas values of Kansas's implementation of the Patient Protection and Affordable Care Act."[5] Five days later HHS announced that $241 million in innovator grants had been awarded to eleven states, including $31.5 million to Kansas. Brownback praised this decision, saying that leaders in Kansas had been talking about creating an exchange for a decade and that he took the grant "not to do Obamacare, but to use that to do an exchange that provides a market mechanism, because I think we could use more market forces in health care" (Brownback 2011).

Republicans in the Kansas legislature disagreed with the governor's logic and argued that accepting the grant required him to comply with and implement the ACA. Pressure intensified after at least nineteen Kansan legislators, as well as Governor Brownback's chief of staff and policy director, attended the American Legislative Exchange Council's (ALEC) annual meeting in early August. ALEC's *State Legislator's Guide to Repealing Obamacare* urged states to not apply for any exchange grants and to return any they had received (ALEC 2011). At the ALEC meeting, participants heard from the Heritage Foundation's Edmund Haislmaier, who emphasized the need for "an unrelenting fight [against Obamacare]" with "house by house, floor by floor, room by room combat" and assured attendees that "there will be numerous places and lines of attack where we can undermine this law" (Mooney 2011). Michael Cannon of the Cato Institute argued at the meeting that refusing to pass legislation to set up an exchange is "the most powerful blow that a state can strike against Obamacare" (Kaplan 2012) and that officials who signed the lawsuit and accepted exchange grants were violating their oath of office by implementing a law they believed was unconstitutional (Mooney 2011). Days after the ALEC conference—perhaps in response to arguments from conservatives, as well as pressure from Tea Party groups and some Republican state legislators—Governor Brownback announced he was returning the grant money. Kansas insurance commissioner Sandy Praeger, an independently elected Republican, criticized Brownback's decision. She continued to hold stakeholder engagement meetings to prepare for a state-run exchange should political conditions change.

Kansas was not the only state to return federal grants. In February 2011, Republican governor Rick Scott made Florida the first state to return its $1

5. Letter dated February 11, 2011, from Governor Brownback to Insurance Commissioner Sandy Praeger, obtained through a freedom of information request under the Kansas Open Records Act.

million planning grant. He said he did not "want to waste either federal money or state money on something that's unconstitutional" (Sack 2011). On March 23, 2011, the one-year anniversary of the ACA, Louisiana Health and Hospitals secretary Bruce Greenstein announced that the state would not establish an exchange and would instead return its $1 million planning grant (NCSL 2011). These decisions came on the heels of the ruling by Roger Vinson on January 31, 2011, that the individual mandate was unconstitutional. He was the second federal judge to find the mandate unconstitutional, but the first to argue that because the mandate was inextricably linked with the rest of the law, the entire ACA should be struck down.

In April 2011, Oklahoma governor Mary Fallin announced that she was returning the $54.6 million innovator grant received two months earlier. At this point this was by far the largest grant received by a state, and as of February 2013 it was still the largest grant returned. In March 2010, after accepting the grant, Fallin had argued in a letter to the legislature that "unlike the federal exchange Washington may try to force on us, the exchange we are trying to build offers a positive, free-market alternative to the big government, tax-and-spend plan that is the PPACA." Republican legislative leaders did not agree and pressed her to return the money. Although the Republican-controlled House narrowly approved enabling legislation, Senate President Pro Tem Brian Bingman announced that he would not even hear a bill to authorize an exchange. Senator Bingman celebrated the governor's subsequent decision to return the money, explaining, "It will serve as a defensive strategy that protects Oklahoma from the federal health care law" (Kliff 2011). Fallin ultimately relented, saying that returning the money "accomplishes [her] goal from the very beginning: stopping implementation of the president's health care exchange in Oklahoma."

The status of Kansas and Oklahoma as early innovators—two of only eleven states to receive awards to develop special IT systems—made their reversals particularly significant. However, while Republicans in these states were renouncing their original plans to create exchanges, other Republicans were moving forward. Wisconsin, the other Republican-led state to receive an innovator grant, was at this point still working to create an exchange.

Two Republican governors used executive powers to advance exchange planning. Indiana governor Mitch Daniels—mentioned at the time as a potential Republican presidential candidate in 2012—signed an executive order in January laying the foundation for an exchange. Daniels noted that while many Republican governors "are hoping for either a judicial or

legislative rescue from this impending disaster [of the ACA] . . . we can't count on a miracle. . . . We have no choice but to prepare for the very real possibility that the law takes effect in 2014" (Daniels 2011a). The order stated that "Indiana currently believes a State-created exchange protects Hoosiers from undue federal regulation" and ensures that it will be a nonprofit corporation with minimal regulatory powers (Daniels 2011b). However, Daniels also emphasized that Indiana still had to decide whether it was "appropriate" to proceed with an exchange. Subsequent efforts in 2011 to pass legislation establishing an exchange failed in the Indiana state legislature.

In Mississippi, Governor Haley Barbour, former chair of the Republican National Committee, backed creation of an exchange, a reform he had supported since before the ACA became law. Bills to create an exchange passed both chambers of the legislature but could not be reconciled by a conference committee. State insurance commissioner Mike Chaney, an independently elected Republican, "used a little-known rule . . . to lay the groundwork for the exchange." He interpreted statutory language governing the state's high-risk pool as providing the commissioner with the authority to create an exchange. Chaney argued, "It's not a Republican idea. It is not a Democratic idea. It is a universal idea. . . . It is important that we have an exchange that is designed by Mississippians. Operated by Mississippians. For Mississippians. We don't want an exchange from the federal government that is one size fits all" (Hess 2012). Barbour additionally emphasized the benefits of the exchange for small businesses while downplaying subsidies for the uninsured. His Republican successor as governor, Phil Bryant, backed the exchange during the 2011 gubernatorial campaign and initially continued his support after taking office in January 2012.

Elsewhere, the effects of the rightward shift after the 2010 elections reverberated even in states that voted to create an exchange. Colorado managed to pass exchange legislation even though only thirteen out of thirty-three House Republicans voted for it and none of the fifteen Colorado Senate Republicans supported the exchange. The bill had been introduced in 2010 with bipartisan support, including from Republican cosponsor Amy Stephens, who in 2011 became House majority leader. According to one state official, Stephens "totally under-estimated the opposition she would have from her party for being a sponsor on the bill"; opponents subsequently derided the bill as "Amycare." But an unusual coalition of Democrats and Colorado business groups, including the state chamber of commerce and the state chapter of the National Federation of

Independent Business, came together to win approval of exchange legislation (Goldman 2012).

Exchange planning activity often occurred relatively quietly. An adviser to a Republican governor in a western state reported that the intense rhetoric surrounding the individual mandate and the lawsuit required conservatives who wanted to create an exchange to walk a very fine line. In these conflicted states, the key was to keep planning activities under the radar in order to avoid alarming conservatives whose opposition could, ironically, lead to imposition of a federal exchange. For example, Iowa governor Terry Branstad publicly opposed the ACA but at the same time took steps to plan for a state exchange. Insurance Commissioner Susan Voss related that in one of their first meetings in 2011 Branstad said something to the effect of "I know I've signed the lawsuit and am speaking out against Obamacare—but can you get me the money Kansas just gave back?"[6] The answer to Governor Branstad's question was no, but Iowa was among the twenty-nine states that applied for and received a multi-million-dollar level 1 establishment grant by October 2011. Nine of these twenty-nine states were plaintiffs in the joint lawsuit, twelve were led by Republican governors, and seven were entirely under Republican control.

In other cases, states applied for exchange funding despite previous statements of opposition. For example, in 2010 and throughout much of 2011, the lack of planning activities and stakeholder engagement made it seem unlikely that Arizona would establish an exchange. However, by the fall of 2011 Governor Jan Brewer's office was quietly pursuing exchange funding, and in November 2011 Arizona was awarded a $30 million establishment grant—the fourth-largest level 1 grant to be awarded to that point.

Similarly, in April 2011 Governor Butch Otter used his only veto of the session to block a bill that would have stopped the ACA's implementation in Idaho. Although opposed to the ACA, he feared the bill would prevent Idaho from being able to establish its own exchange and would thus cede state control to Washington. In order to emphasize his continued opposition to the federal government's role in health reform, Governor Otter issued an executive order in conjunction with the veto that returned $2 million in federal grants related to the exchanges and asked the legislature to appropriate $500,000 of the state's own money instead. The executive order

6. As told by Commissioner Voss in the opening plenary session of the 2012 AcademyHealth National Policy Conference.

also banned state agencies from seeking or spending other money related to health reform, except when specifically approved by the governor. In September 2011 Otter invoked this clause of the executive order and authorized the state's Department of Health and Welfare to apply for a $31 million establishment grant; it was awarded $20 million in November 2011. He argued that it was important for Idaho to take the initiative rather than "submitting to a federally established insurance exchange, with all the loss of control over our own destiny that entails" (Otter 2011).

Reversals of position on state exchanges during this second period reflected, in part, the results of the 2010 elections. Ascendant conservatives in some states took a less accommodationist and more combative attitude toward ACA implementation. Concerns also grew about whether state cooperation with the ACA might affect the legal case against it—conservative analysts warned that by moving ahead with exchanges state Republicans risked undermining the constitutional challenge to the ACA. In addition, conservatives increasingly argued that the ACA's exchanges were not in fact conservative after all, since they ceded too much power to the federal government and imposed too much regulation. The Heritage Foundation's Edward Haislmaier declared in September 2011 that the "combined effect of these regulations and grant requirements are that a state would have to agree to surrender any last vestiges of meaningful control over how Obamacare is implemented. Thus, a state would now have no more real control over how an exchange is set up than over one HHS established" (Haislmaier 2011). Overall, then, the argument that states should not cooperate with exchange implementation picked up force, even as some Republican-led states decided to take federal money.

November 2011–June 2012: Supreme Uncertainty

The Supreme Court's deliberations on the ACA's constitutionality loomed over this third postenactment period. The Court's November 2011 announcement that it would hear oral arguments the following March upped the ante for state policy makers, particularly given the start of most state legislative sessions in January and February 2012, impending primary and general elections throughout 2012, and the November 16, 2012, deadline (just ten days after the election) by which states had to declare their intentions (Jones 2012). As one state department of insurance official put it, "The stakes are higher as the deadlines loom larger. There is more stealth activity by bureaucrats trying to implement as much as they can" in case the law is struck down. Democrats became more anxious to pass

legislation establishing state exchanges, while Republicans became emboldened in their attacks and increasingly embraced delay tactics.

The case for delaying exchange implementation gathered additional steam as word spread among conservatives that a glitch in the ACA could make it impossible for people to receive insurance subsidies in a federal, as opposed to state, exchange. While the ACA's text refers to premium tax credits available in state exchanges, it does not explicitly do so for federal exchanges (Adler and Cannon 2011). Legal scholars such as Tim Jost (2011) argue that in practice this drafting error will not actually prevent uninsured persons from obtaining subsidies in federal exchanges. But some conservatives believed that they had discovered another legal Achilles' heel in Obamacare.

The idea (or myth) that states could stop the ACA's insurance expansion by not creating their own exchanges intensified conservative resistance to implementation efforts. The Cato Institute's Michael Cannon was quoted by citizens in public hearings in at least four states (Michigan, Missouri, New Hampshire, and Pennsylvania) arguing that "states have the collective power to deny the Obama administration the legal authority to dispense more than a half-trillion dollars in new entitlement spending, to expose the full cost of the law's mandates and government price controls, as well as to enforce the law's employer mandate—simply by not creating exchanges" (Cannon 2011). Cato and ALEC—the aforementioned conservative group that authored *The State Legislator's Guide to Repealing Obamacare*—sent analysts to visit Republican state legislators and persuade them to follow a path of "absolute non-collaboration" with the ACA, including boycotting the exchanges (Feder and Millman 2012).

Conservative resistance to moving ahead with exchanges thus strengthened in many states during this period, as Republican leaders awaited the Supreme Court's decision on the ACA's constitutionality. Exchange implementation ran into trouble even in states that had received federal planning grants. The New Hampshire Executive Council[7] blocked the $1 million planning grant the state had been awarded. Similarly, the Michigan House prevented the Department of Licensing and Regulatory Affairs from spending its $10 million establishment grant, and the Missouri legislature stopped the Health Insurance Pool from spending its $21 million

7. The structure of New Hampshire's state government is unique, including the largest legislative body in the country (a four-hundred-member House of Representatives) and an Executive Council (a five-member panel serving as an additional check on the governor's power). Contracts exceeding five thousand dollars and money appropriated outside the regular budget cycle require approval by the legislature's Joint Fiscal Committee and the Executive Council.

establishment grant. In April 2012 the Missouri House also passed a bill (H.B. 1534) declaring that any "official, agent, or employee of the United States government who undertakes any act within the borders of this state that enforces or attempts to enforce any aspect of the federal Patient Protection and Affordable Care Act is guilty of a Class A misdemeanor"—despite voting unanimously one year earlier to create the Show-Me Health Insurance Exchange "to comply with the requirements of the federal Patient Protection and Affordable Care Act" (H.B. 609 [2011]).

In Wisconsin, Scott Walker remained one of the last holdouts among the conservative governors keeping large amounts of grant money and supporting establishment of a state exchange. However, in December 2011 Walker announced that although he was not returning the $38 million grant the state had received, he was halting all implementation activities until after the Supreme Court ruling. Walker soon backpedaled even farther in the face of increased pressure. Tea Party members sent him envelopes full of strings to symbolize the strings attached to federal money, and in January 2012 Senator Frank Lasee (R), chair of the state Senate Insurance Committee, announced that he would not allow exchange legislation to progress (Nocera and Millman 2012). Meanwhile, Walker's Democratic opponents collected 1 million petition signatures in response to the labor disputes of 2011, surpassing the threshold to trigger a recall election. Two days after the signatures were delivered, Governor Walker announced that he was giving the innovator grant back to HHS. The recall efforts may have pushed him farther to the right on the exchanges. Given the need to raise large amounts of money, Democrats speculated that he wanted to free himself of any baggage that may have troubled the Tea Party groups from whom he hoped to solicit help in the recall election (an election he went on to win).

In Michigan, planning efforts stalled because of the politics of the impending Supreme Court ruling and 2012 elections. Leaders in the Michigan Senate initially believed that Michigan would be the first state entirely led by Republicans to create an exchange. Republican governor Rick Snyder supported the idea, the bureaucracy prepared for its implementation, and enabling legislation passed the GOP-controlled Senate in late 2011. However, even though some political insiders believed that enough support existed to move the bill through the House Health Policy Committee and that the decision to wait until after the Supreme Court ruling in June would cost the state an opportunity to receive the level 2 establishment grant, Chairwoman Gail Haines said she would not bring the bill up for a vote until the Court's decision was announced (Haines 2012).

Meanwhile, the House blocked state agencies from spending the $10 million level 1 establishment grant it had received. With uncertainty over the law's fate in the courts and subsequently in the legislature, and without money for implementation, exchange planning slowed in Michigan.

In Ohio, Governor John Kasich and Insurance Commissioner / Lieutenant Governor Mary Taylor, both Republicans, faced off on the exchange issue. Taylor, an outspoken critic of Obamacare, opposed the creation of an insurance exchange. Although Kasich also opposed the ACA and ensured that the new Republican attorney general signed the lawsuit immediately after he took office, he supported a state exchange in order to avoid ceding control to the federal government. But moving forward with an exchange would mean putting a strong critic in charge, giving Taylor a new role, or somehow creating a state insurance exchange without involving the insurance department. Progress on an exchange thus stopped in Ohio before it ever began.

Rising opposition to exchanges promoted concern from health care stakeholders. In fact, in some cases, groups opposed to the ACA—such as chambers of commerce and NFIB chapters—strongly encouraged states to create their own exchanges. They feared that moving control from state capitals to Washington would result in stricter regulation and rules unfavorable to local market conditions. Segments of the insurance industry, which could profit from expanding markets, also supported the exchanges and in some cases worked to advance their creation. The Blue Cross and Blue Shield Association hosted a meeting in November 2011 for its member plans on how to overcome conservative state opposition to exchanges (Nocera 2011), including using potentially more positive terminology such as "marketplace"—language that the Obama administration would later embrace.

Other Republican-led states continued to apply for exchange grants. On February 22, 2012, HHS announced that it had awarded ten more level 1 establishment grants, bringing the total number of states to thirty-four. Pennsylvania and Tennessee, two of the new grantee states, were led entirely by Republicans, and Republicans controlled either the executive branch or at least one chamber of the legislative branch in five other grantee states.

Finally, some governors asserted executive power to circumvent legislatures. In New York, Democrat Andrew Cuomo issued an executive order establishing an exchange, thereby surmounting opposition by Republicans in the state senate. In New Jersey, Republican Chris Christie vetoed exchange legislation passed by Democratic majorities in the General

Assembly and the Senate. Christie's decision epitomized the influence of the Supreme Court case on state Republicans. He argued that the ACA's constitutionality "is cloaked in uncertainty" and "because it is not known whether the Affordable Care Act will remain, in whole or in part, it would be imprudent for New Jersey now to create an exchange before these critical threshold issues are decided with finality by the court" (Christie 2012).

In summary, Republicans were still divided over what to do about the exchanges. However, the division was not the same in early 2012 as in late 2010. A number of early advocates switched to opposition, while some early opponents switched to implementation. Meanwhile, many Republican state leaders remained in a holding pattern, waiting to see whether the Supreme Court would overturn the ACA or whether the 2012 elections would enable the GOP to repeal it.

July 2012–March 2013: Decisions and Deadlines

On June 28, 2012, the Supreme Court issued its much-anticipated ruling on the constitutionality of the Affordable Care Act. With Chief Justice John Roberts writing for a 5–4 majority, the Court ruled that the individual mandate was functionally equivalent to a tax, making it constitutional under Congress's power to levy taxes (KFF 2012). Obamacare had narrowly survived. However, in a surprise move, the Court found that the ACA's Medicaid expansion coerced states and that the federal government could not take away existing Medicaid payments from states that didn't expand their programs. The ACA's Medicaid expansion effectively became optional for states, opening up another, unexpected front in state resistance to health care reform.

The Court ruling upholding the ACA meant that one of Republicans' major hopes for overturning Obamacare had evaporated. Seeking to win over more states, the Obama administration announced the day after the ruling that it would extend the deadline for the level 2 establishment grant through December 2014. Although the extension in effect rewarded states that had delayed exchange planning, the administration offered resisting states a new way out of their dilemma. In August, HHS released final rules for Partnership Exchanges, in which states would operate exchange functions related to insurance plan management and consumer assistance while allowing the federal government to take responsibility for other functions, such as establishing the necessary IT infrastructure. The partnership option provided a potentially attractive way forward for states that

were unable to implement a state-based exchange in 2013 but were unwilling to cede all operational responsibility to the federal government.

Overall, the landmark Court decision had little impact on state exchange activity. States that had enabling legislation or an executive order continued to actively implement their exchanges, while states that had delayed making a decision continued to wait. Even after the Court's decision, many Republican state leaders still hoped that the 2012 elections would lead to the ACA's demise.

President Obama's reelection four months later, along with the Democrats' expansion of their Senate majority, transformed the politics of health reform implementation. The day after the election, Speaker of the House John Boehner declared that "Obamacare is the law of the land." The ACA would not be repealed, and its major provisions, including the exchanges, would go forward (Oberlander 2012). Since uncertainty over the ACA's fate had vanished, states could no longer hedge their bets. The GOP would have to live with Obamacare, and state Republicans had little time to accommodate that reality—the deadline for submitting a blueprint for a state-based exchange came just ten days after the November 6 election.

Republican-led states reacted in different ways to the changed landscape. Republican governors such as Terry Branstad (IA), Bill Haslam (TN), and Bob McDonnell (VA) considered moving forward, but ultimately decided not to pursue state exchanges. The Obama administration tried to convince these states to build their own exchanges—just as it did immediately after the Supreme Court ruling, HHS extended key deadlines shortly after the November elections. The Republican Governors Association asked for more time to decide, as well as for answers to what they considered unresolved questions. Secretary Sebelius (2012a) responded that states were still required to submit a letter of intent by November 16 but could wait until December 14 to submit a blueprint for a state-based exchange and until February 15, 2013, to submit a blueprint for a partnership exchange. On the eve of the November 16 deadline, Secretary Sebelius (2012b) told states that they could also wait until December 14 to submit letters of intent. By mid-January, HHS's message was that "there is no deadline" and that states could at any point decide to take control of their exchanges (Pear 2013).

At this point Florida governor Rick Scott, an ardent ACA opponent, expressed a willingness to consider creating an exchange. He told a reporter, "The election is over and President Obama won. I'm responsible for the families of Florida. . . . If I can get to yes, I want to get to yes" (Baker 2012). Governor Scott met with Secretary Sebelius in early January 2013,

but ultimately did not submit proposals for either a state-run or partnership exchange.

In fact, only three Republican governors newly decided to pursue a state-based exchange following the 2012 elections: Governors Rick Snyder (MI), Susana Martinez (NM), and Butch Otter (ID). In Michigan, Governor Snyder had supported creating an exchange from the beginning, but the state House Health Policy Committee would not vote on enabling legislation until after the Supreme Court's ruling and the November elections. With the law surviving these challenges, House leadership pushed for a state-based exchange, but failed to move the bill out of committee. In the end, the Snyder administration compromised by formalizing a decision to create a partnership exchange.

Governor Martinez had vetoed an exchange bill in 2011, but after the 2012 elections announced her intention to move forward with a state-based exchange. The state's human services secretary, Sidonie Squier, explained, "The party is over. The opposition is over. Whatever states didn't think they were going to do it, I think they're going to have to do it whether they like it or not. It's a done deal now" (Alonso-Zaldivar 2012). Ironically, Governor Martinez had a hard time gaining support from Democrats, because she wanted to create the exchange without passing new legislation, as part of the New Mexico Health Insurance Alliance. Democrats contended that the alliance's board tilted too heavily toward the insurance industry and instead moved forward with their own legislation. The two sides came together and ultimately passed a bill in late March 2013.

Governor Otter had long been trying to thread the needle on an exchange, vehemently opposing the ACA but still preserving the option to take state control. Otter ultimately submitted an application to do so by the December 14 deadline. HHS's conditional approval of Idaho's exchange came days before the start of the new legislative session in January 2013. In his "state of the state" speech four days later, Otter (2013) told legislators,

> You all know how I feel about Obamacare. I will continue encouraging and supporting efforts by our Idaho congressional delegation and many others to repeal and replace the law. But the fact remains that for now and for the foreseeable future it is the law. And as responsible elected officials we're sworn to uphold the rule of law—not just those laws that we support. So I urge you to look beyond the important work of changing a misguided federal law to the essential task at hand for those of us in the chamber today—preserving for Idaho citizens the option of having a voice in how one element of that law is implemented.

Republican lawmakers in Idaho were divided over how to respond, but enabling legislation ultimately passed, and Governor Otter signed it into law in late March 2013. Given that the state had so little time to develop the exchange before open enrollment in October 2013, the Obama administration agreed to a de facto partnership in which Idaho policy makers have the opportunity to make the decisions that they care most about while leaving many of the aspects of creating an exchange that they care least about to HHS.

Finally, in some states Republican opposition to an exchange hardened following the elections. In North Carolina, outgoing governor Beverly Purdue (D) had submitted plans to run a partnership exchange and had accepted a level 1 establishment grant to finance planning efforts, but North Carolina Republicans won the governorship in the 2012 elections and strengthened their majority in the legislature. In 2013, the state House and Senate quickly passed legislation aimed at preventing North Carolina from participating in a partnership exchange, and Governor Pat McCrory (R) announced his opposition as well.

Another retreat from a state-run exchange came in Mississippi, where independently elected insurance commissioner Mike Chaney (R) submitted a proposal to HHS despite opposition from Governor Phil Bryant (R). Governor Bryant had supported creating an exchange during his 2011 campaign but backed off his support, particularly after Republicans gained control of both legislative chambers in 2011 for the first time since Reconstruction. Commissioner Chaney said he wished the law had been repealed, but decided to follow through with plans to create a state-based exchange because he believed that failure to act would "forever give the keys to the state's health insurance market to the federal government" (Alonso-Zaldivar 2012). But Bryant made it clear to HHS that he did not support the application submitted by the state's insurance department. In a letter to Secretary Sebelius he wrote, "I oppose the expansion of the Affordable Care Act in the State of Mississippi, and I believe the health care exchange is a gateway for that. It is inevitable that such an exchange will be controlled by the federal government, not by the State. The federal government has never provided funds for a program without ultimately seizing control of it" (Bryant 2012). Mississippi's Democratic attorney general, Jim Hood, weighed in as well, declaring that the insurance department had the authority to submit an application on the state's behalf. The next day, Governor Bryant (2013) wrote another letter to Secretary Sebelius indicating that he had advised the state's Division of Medicaid not to cooperate with an exchange. Citing the lack of support from the governor

and resulting agency coordination problems, HHS subsequently rejected Commissioner Chaney's proposal (Cohen 2013), making Mississippi the only state to have an application rejected. In its rejection letter, HHS noted that Mississippi would be an excellent candidate for a partnership exchange; however, the state did not apply for a partnership.

Even after the Supreme Court ruling and 2012 elections ended Republicans' dream of repealing Obamacare before implementation of major provisions, GOP opposition to exchanges remained strong. Out of thirty states led by Republican governors in 2013, only four are creating their own exchange. Other Republican leaders are focusing on alternative ways to undermine the exchanges, including limiting congressional appropriations for their operation and challenging the federal government's legal authority to provide subsidies in exchanges not run by states.

Understanding the Controversy and Shifting Responses

That most states refused the opportunity to establish their own health insurance exchanges is a surprising, even stunning, outcome. State nonimplementation of health exchanges highlights an important puzzle. Why has there been so much controversy over and resistance to an idea that previously enjoyed broad bipartisan support?

In contrast to the exchange controversy, states did not broadly resist implementing the State Children's Health Insurance Program (SCHIP) after its 1997 enactment. All states had created SCHIP programs by the fall of 1999 (Kenney and Chang 2004). States embraced SCHIP even though it was government-sponsored health insurance—and thus presumably closer to "socialized medicine" in Republicans' eyes (though many state SCHIP programs actually contracted with private insurers). In the case of SCHIP, as with Medicaid, states directly received money to pay for enrollees' care, money that they have undertaken to maximize and use in creative ways. However, under the ACA states do not directly receive insurance exchange subsidies, diminishing their incentive to establish exchanges. In addition, SCHIP covered a sympathetic population—a children's exchange would probably be more difficult to oppose than an exchange for uninsured adults. And crucially, the original SCHIP legislation passed, unlike the ACA, with significant bipartisan support in Congress.[8]

8. However, in a harbinger of the ACA's polarizing politics, there were partisan divisions during the 2007 SCHIP reauthorization debate. President Bush vetoed reauthorization legislation, arguing that program expansion was a step "down the path to government-run health care for every American" (Oberlander and Lyons 2009: w405).

Indeed, that state exchanges became controversial at all is a testament to the intense, enduring partisan divide over the ACA. While conservatives criticized the ACA's exchanges for embracing too much regulation and imposing overly stringent requirements on states (Haislmaier 2011), the law's exchanges are strikingly similar to the organized purchasing pools that many Republicans previously supported. The absence of both a national exchange and a public option within the exchanges should have made them even more palatable to Republicans. Were similar exchanges part of a health reform law sponsored by a Republican administration, we doubt that as many Republican states would have opposed their implementation.

State Republican resistance to health reform may reflect increasing levels of partisan and ideological polarization in contemporary American politics at both the national and the state levels (McCarty, Poole, and Rosenthal 2006; Shor and McCarty 2011). Exchange politics were substantially, though not exclusively, partisan: 88 percent of Democratic state legislators voted for legislation establishing exchanges, while only 42 percent of Republicans did so. That level of support among GOP state legislators contrasts with congressional Republicans' unanimous vote against the ACA and underscores exchanges' broad political and ideological appeal. Nonetheless, states' ultimate decisions on exchanges reveal a strong partisan divide. Barack Obama carried twenty-five states and the District of Columbia in the 2012 elections. Out of the seventeen states establishing their own exchanges, President Obama won fourteen of them. In the fourteen states that voted for Obama and have a Democratic governor, eleven are creating state exchanges, and the remaining three are opting for partnership exchanges. In the seven states Obama won that are defaulting to a federal exchange, none has a Democratic governor. By contrast, only three of the twenty-five states that Mitt Romney carried are creating exchanges, with another three pursuing partnership arrangements. And only four Republican governors currently preside over states that intend to operate their own exchanges. Clearly, then, party control of state government, states' ideological predispositions, and state voting patterns in presidential elections are strongly associated with state decisions regarding exchange implementation.

Ensnared in a broader partisan struggle over the ACA, exchanges became another front in the battle over the role of government. Exchanges became controversial largely because they suffered from guilt by association—with Democrats, President Obama, and Obamacare. Giving states control

over establishing exchanges was supposed to promote decentralization and dampen charges of a federal "takeover" of the health system (Sparer 2011). But that embrace of federalism became a source of tension (Jennings and Hayes 2010). Exchanges emerged in many states as unlikely targets of the fervor against Obamacare; instruments of compromise were transformed into objects of conflict. Opponents took advantage of the legislative process required to authorize exchanges to refight the health care debate. In a polarized political environment, even popular and seemingly benign reforms can appear to ACA opponents to be serious threats and slippery slopes leading to socialized medicine.

The Tea Party's rise and the rightward shift in state governments after the 2010 elections contributed to the exchange controversy. The Tea Party movement—fueled by resistance to the ACA—was at least partly responsible for giving Republicans large majorities in many state capitals. Tea Party activists and politicians generally favored total opposition to the ACA law and noncooperation with exchanges: Republicans implementing any part of the ACA have been branded as traitors. Moreover, while only about thirty of the nearly five thousand incumbent state legislators running for reelection in 2010 were defeated by Tea Party candidates,[9] a handful of high-profile victories over Republican establishment candidates—including the defeat of three-term Utah senator Robert Bennett, who had coauthored a bipartisan health care bill—amplified the Tea Party's perceived power (Karpowitz et al. 2011). Republican incumbents consequently had reason to fear that health reform apostasy on the exchanges could hurt their electoral prospects. Tea Party opposition changed the politics of exchanges by creating a vocal force for noncompliance within the Republican base—one that could counter efforts by some insurers and small business associations to lobby for exchange implementation. Republican governors such as Scott Walker in Wisconsin and Nathan Deal in Georgia reversed initial support for exchanges after facing Tea Party pressure.

Indeed, interstate differences in the strength of Tea Party groups may help to explain why some GOP-governed states and legislatures supported exchanges while most Republicans rejected them. Reliable state-level measures of Tea Party strength are hard to come by. But of the twenty states with the largest Tea Party presence on meetup.com in March 2012, only Nevada and Utah are creating an exchange, and as previously noted, Utah

9. According to analysis based on the list of defeated incumbents at www.ballotpedia.org/wiki/index.php/Incumbents_defeated_in_2010's_state_legislative_elections (last modified August 8, 2012).

did so in 2009 before the ACA's enactment.[10] Moreover, of the eighteen states with exit polls conducted by Roper during the 2010 elections, support for the Tea Party reached 40 percent in twelve (Roper Center n.d.). Republicans controlled the executive branch and at least one chamber of the legislative branch in eight of these states. None of them opted to create a state-based exchange, and only three received an establishment grant as of September 2012. By comparison, all four states with 40 percent Tea Party support but led by Democratic governors are either creating a state-based exchange (Colorado and Kentucky) or a partnership exchange (Arkansas and West Virginia). Republican incumbents in states with a more active Tea Party movement may have felt pressure to abide by the Tea Party's hard-line stance on exchanges because they were afraid of primary challenges.

Finally, the considerable intra-Republican divisions that emerged in many states are worth noting again. These divisions highlight both the institutional opportunities for and obstacles to implementing exchanges at the state level, as well as the diversity of GOP policy makers' views on exchanges. In some cases, Republican governors and even an insurance commissioner, in Mississippi, attempted to use executive powers to push an exchange forward over the objections of state legislators. In other cases, like Michigan, legislators opposed to an exchange exploited institutional veto points to stop its progress despite support from the Republican governor. And in Alabama, Republican legislators supporting establishment of an exchange ran up against opposition from the state's Republican governor, who threatened to veto any bill that would create an exchange.

Conclusion

Health insurance exchanges started as a relatively uncontroversial part of the ACA. While the individual mandate and other provisions attracted considerable controversy, the idea of creating state-run, regulated insurance marketplaces for the uninsured and small businesses appeared to have broad bipartisan appeal. States were widely expected to jump at the chance to operate their own exchanges, and even states whose leaders opposed the

10. Meetup.com has been described in the literature and the press as a way for Tea Party groups to coordinate. We searched meetup.com using the phrase *tea party* in states with Republican governors. The results listed both the number of groups and the number of people per group. Although this is an imprecise way to measure Tea Party presence in a state, this website has been described as an important grassroots tool for organizing.

ACA were presumed to prefer running exchanges to surrendering control to Washington.

Yet after initial receptiveness to the opportunity, only seventeen states and the District of Columbia ultimately chose to establish state-run exchanges for 2014, with another six states opting for a partnership model. The pervasive resistance to Obamacare was so strong that many states decided to cede control of the exchanges to the federal government—an extraordinary outcome that reflects growing levels of partisan polarization. The peculiar politics of exchanges meant that in opposing Obamacare, many Republican-led states paradoxically protested a federal "takeover" of the health care system by giving Washington the power to take over exchanges in their states.

Ironically, resistance by conservative states has ended up giving liberal Democrats what they originally wanted: a large federal role in establishing and operating exchanges across the country. But Washington will play a role in building exchanges in many more states than anticipated, complicating the task of getting these new marketplaces up and running in time for the first open enrollment period during the fall of 2013. Indeed, HHS is even assisting states such as Idaho and New Mexico that have chosen to establish their own exchanges but made the decision too late to get everything online in time.

It remains to be seen how well federal policy makers will manage the formidable challenge of administering exchanges in diverse health care markets without state cooperation and with only limited funds for implementation. The Obama administration's preference for having states play a leading role in operating exchanges is evident in its decision to approve Utah's request for a bifurcated exchange that will include both a state-run purchasing pool for small businesses and a federally run exchange for the individual insurance market. Still, in the long run, a larger federal presence could mean exchange rules that are more uniform across the country.

States can shift their positions on exchanges over time, so it unclear how the current division among state-run, federally facilitated, and partnership exchanges will change in response to accumulating experience with health reform implementation, new political alignments, and fluctuating economic and budget conditions. If Republicans view state exchanges as successful, and if insurers pressure them to find a way out from federal oversight, more GOP leaders could decide to embrace state-run exchanges (or "marketplaces"—exchanges have become sufficiently controversial that HHS now prefers the marketplace label). Pragmatism and growing acceptance that the ACA is here to stay could eventually override ideology

and partisanship. But if the exchanges' initial performance is disappointing, it could reinforce Republican opposition to playing a role in their operation. Republican victories in the 2016 presidential and congressional elections could create more uncertainty over the future of exchanges and the ACA.

Having decided what to do—or not do—about exchanges, states are now turning their attention to Medicaid. The Supreme Court ruling that effectively makes Medicaid expansion optional has created a new political dilemma for Republican state leaders, especially since the Medicaid expansion comes with the lure of considerable federal dollars. States that refused to establish their own exchanges now must decide whether to double down on that opposition by rejecting the Medicaid expansion as well, or give in to more pragmatic fiscal, economic, and political considerations, including pressures from hospitals eager to reduce their uncompensated care bills. The debate over state implementation of Obamacare rages on.

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