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State Implementation of the Affordable Care Act: Four Case Studies

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The Affordable Care Act (ACA) has been the subject of one of the most contentious policy issues in recent memory. Previous research has tracked the volatility of state decisions over a three-year period, 2012, 2013, and 2014, using an index ranking states by their policy decisions regarding whether they were in support or opposition to the ACA. The present study suggests state legislatures may increasingly be making health-care choices based on the needs of the citizens in the state and less on partisanship. This article employs a case study methodology to examine the health-care policy decisions made in four states: Alabama, which ranked as one of the staunchest opponents; Michigan, which scored as neutral; California, which scored as highly supportive; and New Hampshire, which moved from opposition to support during the reviewed three-year time frame. This research examines influences driving these decisions at the state level.

Keywords: Health Policy, Health Care, Patient Protection and Affordable Care Act, Obamacare, ACA, United States, State and Local Politics and Policy, Alabama, California, Michigan, New Hampshire, State-Level Decision Making.

Related Articles:
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El Affordable Care Act (ACA) ha sido el tema de una de las discusiones políticas más contenciosas de la historia reciente. La investigación previa (Mayer, Kenter, & Morris, 2017), monitoreó la volatilidad de las decisiones de estado en un periodo de tres años, 2012, 2013 y 2014, utilizando un índice que organiza a los estados según sus decisiones políticas acerca de si apoyaban o no la oposición al ACA. Esta investigación sugiere que las legislaturas estatales pueden estar tomando más y más decisiones basadas en las necesidades de los ciudadanos en el estado, y menos en el partidismo. Este artículo emplea una metodología de estudio de caso para examinar las decisiones de política de la salud tomadas en cuatro estados: Alabama, que quedó como uno de los opositores más fervientes; Michigan, que quedó como neutral; California, que resultó tener altos niveles de apoyo; y Nuevo Hampshire, que cambió de ser opositor a apoyar durante los tres años de examinación. Esta investigación examina las influencias que motivan estas decisiones a nivel estatal.

Palabras Clave: políticas de salud, atención de salud, atención médica, Affordable Care Act, Obamacare, ACA, Estados Unidos, política y políticas estatales y locales, Alabama, California, Michigan, Nuevo Hampshire.

平价医疗法案（*The Affordable Care Act, ACA*）一直是近期事件中最具争议的政策议题之一。之前的研究（*Mayer, Kenter, & Morris, 2017*）追踪了各州在*2012-2014*年间飘忽不定的决策，追踪方法则是使用索引将各州依照自身对于*ACA*持支持或反对态度而采取的决策进行排序。本研究暗示，州立法机关在制定医疗政策时，可能越来越多地基于州内公民的需求，而不是党派偏见。本文使用一项案例研究方法，检验了*4*个州的医疗政策决定，其中阿拉巴马州是最坚定的*ACA*反对者之一，密歇根州持中立态度，加利福尼亚州则高度支持，

新罕布什尔州在被检验的三年间从反对转移到了支持。本研究检验了在各州驱动这些决定的影响因素。

关键词：卫生政策，医疗卫生，*Healthcare*，平价医疗法案，奥巴马医改，*ACA*，美国，国家和地方政治及政策，阿拉巴马州，加利佛尼亚州，密歇根州，新罕布什尔州。

The Patient Protection and Affordable Care Act (ACA) of 2010 has proven to be one of the most hotly debated and politically contentious national policy initiatives in decades. A cornerstone of the Obama presidency, the legislation represents the most comprehensive overhaul of national health-care policy since the 1960s. The legislation included several initiatives to address health-care policy, including a national expansion of Medicaid, a plan to increase health insurance coverage for millions of Americans, and other programs to control health-care costs and increase market efficiency. Championed by those on the ideological left and roundly condemned by those on the right, the ACA has been a touchstone of the ideological divide since its passage in 2010.

The law has been implemented in planned stages since the latter part of 2010, a process that continues as of this writing. The ACA has withstood several court challenges (see Mayer, Kenter, and Morris 2015), and was the focus of much of the debate surrounding the 2016 election season. As a candidate, Republican nominee Donald Trump proclaimed that his first act as president would be to repeal the ACA, a promise echoed by Republican candidates in House and Senate races around the nation. While the fate of the ACA is unclear at this time, current efforts to repeal the ACA and replace the law with an alternative have met with stiff political opposition, even from a number of Republicans unhappy with the current proposals.

The ACA was structured in such a way to allow states to make several choices in the implementation phase of the law. In addition, empirical evidence suggests that states took a wide range of different paths in terms of their support or opposition to the ACA (see Barrileaux 2013; Barrileaux and Rainey 2014; Haeder and Weimer 2013; Travis *et al.* 2016). This previous research has sought state-level explanations of implementation decisions, typically employing a 50-state model to identify common factors in state choices (see e.g., Barrileaux and Rainey 2014; Mayer, Kenter, and Morris 2015). While these efforts paint broad-brush policy choices, they fail to capture the dynamics present in each state.

Previous work by Mayer, Kenter, and Morris (2015) and Travis and others (2016) employed a dependent variable designed to capture a broad range of state efforts to accept or oppose the ACA. Following on that previous work, and employing a similar framework, this article seeks to examine the specific conditions in states that led to their decisions. To do this, we present four case studies: one state that was strongly opposed to the ACA; one state that fully

supported the ACA, and one state that fell in the middle of the range. Our fourth case represents a state that moved from opposition to acceptance of the ACA. By examining the conditions and issues present in these states, we can better understand the decisions made by these states across a range of policy positions.

This work is important for several reasons. First, if states are truly "policy laboratories" (Dror 1968), then an in-depth examination of state choices provides a more complete understanding of the choices made by states. Indeed, the ACA was written in such a way that it allows states to make several decisions that determine the implementation of the law in that state. A number of states also took specific actions to deny implementation altogether, while still other states embraced the policy. The reasons behind these state choices are brought clearly into focus in this study. Second, while 50-state statistical models are exceptionally useful for identifying national trends, the methodology is limited by the ability of the researcher to identify all potentially interesting variables, in part because of the cases/variables limitation of small-*n* implementation studies (see Goggin 1986). A qualitative approach allows a more nuanced examination of the factors that led states to make the decisions they did. Finally, case study work allows the ability to confirm the validity of the dependent variable developed for the statistical models employed in earlier research efforts.

We begin this article with a review of the ACA, and a brief discussion of the elements of the dependent variable developed for previous statistical analysis (see Mayer, Kenter, and Morris 2015; Travis *et al*. 2016). We then present a discussion of the four case study states (Alabama, Michigan, California, and New Hampshire). We conclude with some thoughts about the utility of case study research in this policy arena.

Background of the Affordable Care Act

In the spring of 2010, President Obama signed into law the ACA and the amending Health Care and Education Reconciliation Act. As President Obama's signature policy achievement, the law was designed to provide affordable health care to all citizens and curb escalating health-care costs. While President Obama succeeded where many others had failed in passing health-care legislation, it was a highly contentious period, fueled by bitter partisan divide and resulting in a number of legal and constitutional challenges.

Among the primary concerns were the federal government's ability to tie Medicaid funding to state expansion decisions and the legality of the individual mandate that required qualifying citizens to purchase and maintain coverage or risk escalating tax penalties. In a combined lawsuit, the U.S. Supreme Court upheld the constitutionality of the law, ruling the mandate to be a legitimate exercise of congressional taxing power, yet overturning the coercive appropriations language. The ruling provided legitimacy to the ACA while also undermining the

original intent of the law by allowing states to determine their level of participation without fear of losing federal funding.

This ruling left states with several key decisions to make regarding implementation and their support or opposition of the ACA. The first decision was whether or not to accept the federal funds and proactively expand Medicaid, or to refuse in active defiance. To facilitate the program, insurance exchange marketplaces had to be created within each state. States were given the option to design their own exchanges within the federal framework, participate in a joint exchange, or default to the federal administration. The exchanges were intended to facilitate coverage, offering plans, and providing credits and subsidies to those with household incomes between 133-400 percent of the federal poverty level. In addition to deciding whether or not to expand Medicaid and create an insurance exchange, several states also chose to pass legislation in support or defiance of the ACA. A number of these states further voiced their opposition through participation in a series of state and federal lawsuits challenging specific segments of the ACA in an attempt to undermine and impede the implementation of the ACA within their state.

Methods

Through a case study design, this study builds on prior work (Mayer, Kenter, and Morris 2015), examining state policy decisions with regard to the ACA and the volatility of the initial implementation over a three-year period: 2012, 2013, and 2014. The prior research employed a five-component dependent variable measuring levels of support and opposition to the ACA and how they evolved during the initial three-year period of implementation. States were scored on whether they adopted legislation in support of health-care market reforms, whether they created an insurance exchange, if they accepted Medicaid expansion funds, whether they participated in a lawsuit challenging the ACA, and finally whether they passed legislation designed to impede the implementation of the ACA.

For instance, California was scored at the highest level of support on the index. California created a state exchange (+1), expanded Medicaid (+1), and adopted legislation in support of the ACA (+1). California chose not to participate in the federal lawsuits challenging the constitutionality of the ACA and chose not to enact state legislation impeding the ACA, so no points were deducted. California's resulting opposition/support score is +3, indicating California law makers are in support of the ACA.

Utilizing this framework in a case study design allows for additional insight into state-level dynamics and decision making beyond the prior quantitative work. This study examines the above-referenced support and opposition factors in four states: Alabama, which ranked as one of the most staunch opponents across the reviewed time frame; Michigan, which scored as neutral in its level of support for the ACA; California, identified consistently as one of the most

supportive states; and New Hampshire, which exhibited the greatest movement from opposition to support during the reviewed three-year period.

We chose this combination of states in order to compare and contrast state implementation decisions across the range of choices available. The selection of the four states and the findings highlight the internal divisions and debate that took place across the country. Examining four states that scored very differently with regard to their support and opposition of the ACA illustrates the difficult and arduous decision-making process, not just in divided states but also states on each extreme of the policy spectrum. Further, by examining both support and opposition measures within the four states, we can begin to compare and contrast the major factors driving state-level decision making and start to explain why some states actively resisted, others took several proactive measures, and others still did very little with regard to the implementation of the ACA.

Case Studies

Alabama

Alabama represents a state that took an exceptionally strong position against implementation of the ACA at the outset, a position that changed little over time. Alabama's strategy was to oppose implementation in every way possible, a strategy they implemented with gusto. Alabama's legislature was among the first in the nation to pass legislation in opposition to the ACA, and the state was among the first to file suit to block implementation of the law.

Alabama is a state dominated by conservative Republicans, a situation that was solidified in 2010 when the Republicans gained control of both houses of the state legislature for the first time since Reconstruction. Republican presidential candidates have carried the state, with two exceptions, in every election since 1960 and six of the seven congressional representatives from Alabama are Republican; the lone exception represents the largely Black district in West Alabama (Orndorff 2011). By every measure, Alabama is a solid "red" state. This solid party control allowed state policy makers to oppose ACA implementation in the strongest manner possible, and largely without effective opposition.

Alabama is also a state in which there are a large number of uninsured citizens; roughly 16 percent of citizens are uninsured, and an additional 20 percent of the state's population receives benefits from Medicaid (Orndorff 2012). Although uninsured whites make up the majority of the uninsured population, a disproportionate number of minority citizens are uninsured. The insurance market in the state is dominated by Blue Cross/Blue Shield of Alabama (BCBSAL) with some 91 percent of the private insurance market (Rockefeller Institute 2014); the remainder is a combination of three other companies. The insurance market is largely noncompetitive, and a lawsuit filed in federal court

in Birmingham against BCBSAL seeks an antitrust verdict to make the market more competitive.

State Exchange

Alabama applied for, and was awarded, two federal grants totaling about $9.6 million for planning a state exchange (Rockefeller Institute 2014). These grants were designed to assist states in the planning and execution of a state exchange. In mid-2012, Governor Robert Bentley expressed some public support for the state exchange, but warned that Alabama would wait until the last minute to make its exchange operational (Chandler 2012e), pending a decision by the U.S. Supreme Court on the legality of the ACA. Citing his experience as a physician, and not politics, Governor Bentley became increasingly vocal about his opposition to the state exchange and vowed to wait until the outcome of the November 2012 presidential election to make the state's exchange operational in hopes that the ACA would be repealed by a Republican president and Republican-controlled Congress (Chandler 2012d). In late 2012, Governor Bentley announced that Alabama would not create a state exchange (Chandler 2012c), and instead would rely on the federal option (Rockefeller Institute 2014). In that announcement, Bentley expressed the opinion that by joining several other states refusing to set up state exchanges, the states could force Congress to revise or repeal the ACA (Chandler 2012b).

Medicaid Expansion

The state's position on Medicaid expansion has remained relatively consistent over time. Alabama operates one of the most bare-bones Medicaid programs in the nation, although the current program serves almost 20 percent of the state's population (Orndorff 2012). A 2012 study by health economists at the University of Alabama at Birmingham predicted a net state tax revenue gain of about $935 million as a result of Medicaid expansion (Rockefeller Institute 2014, 6). However, the state's Attorney General, Luther Strange, joined with other Republican state attorneys general in a lawsuit challenging the constitutionality of the Medicaid expansion portion of the ACA, a suit that ultimately failed. Governor Bentley remained a staunch opponent of Medicaid expansion, announcing in November 2012 that Alabama would not expand its Medicaid program. Said Bentley, "I will not expand Medicaid as it exists under the current structure because it is broken. . . [i]t is, in my opinion, truly the worst piece of legislation that has ever been passed in my lifetime," while still maintaining his resistance to the ACA was a matter of philosophy, and not politics (Chandler 2012b, 7-A).

State Legislation

One of the earliest statements of opposition to the ACA came in the form of legislation passed in 2011 that put a constitutional amendment before voters to allow employers, health-care providers, and individuals to opt out of any

health-care system. A direct challenge to the ACA, the amendment would have effectively bypassed the governor from the decision process if approved by voters. While many observers saw the initiative as largely symbolic, it was a clear statement of opposition to the ACA. As one state senator stated, "The people of Alabama don't want any part of Obama's national legislation" (White 2011, 10A).

The state legislature was also charged with developing legislation to enable the creation of a state insurance exchange, and to pass needed insurance market reforms. Governor Bentley initially supported state exchange (Chandler 2011), but a bill to create the exchange died in the Senate after some questioned whether the legislation would create a virtual monopoly for BCBSAL. Several law makers noted that BCBSAL was the only company in Alabama that would qualify to join the exchange, and that the result would not be an open marketplace (Chandler 2012a). The state legislature showed no interest in creating market reforms to encourage a more robust insurance market in the state.

Summary

Alabama represents a state at the extreme end of the scale of opposition to the ACA. However, it is important to note that the "extreme no" position was not necessarily present initially; there is clear indication that the state's extreme position developed over time as a result of internal political and economic circumstances. In spite of evidence that the ACA would be beneficial to citizens, the state's economy, and state revenue, strong partisan opposition ultimately ensured that the ACA would be resisted by every means possible. The lack of a robust competitive private insurance market in the state complicated the process, but intentional delays and active partisan opposition means that Alabama stands as the exemplar case for a state in opposition to the ACA.

Michigan

Located in the upper Midwest, Michigan is the tenth most populous state in the country. Nearly 20 percent of the citizenry reside in Wayne County, with the largest proportion calling Detroit home. Like many large Midwestern manufacturing cities of the twentieth century, Detroit has experienced significant challenges adapting to the deindustrialization of the country in the latter half of the twentieth century. Detroit has lost more than half of its population over the past 40 years, and for the first time since the Fillmore Administration in 1850, has fallen out of the 20 most populous cities in the country (MacDonald 2016). With the loss of hundreds of thousands of manufacturing jobs, the state of Michigan, by 2010, had nearly four million citizens, or roughly 40 percent of the citizenry, who were uninsured or receiving some form of public subsidy (Stock *et al*. 2010).

The ACA sparked a substantial and heated debate across the country and within the state of Michigan over the constitutionality of the legislation and

how to best implement its provisions. Almost immediately following the passage of the ACA, Michigan Attorney General Mike Cox joined 13 other states in a lawsuit challenging the law's constitutionality. After a protracted debate, Republican Governor Rick Snyder opted to expand Medicaid provisionally and create a state-federal partnership to administer Michigan's new health insurance exchange. Michigan became just one of five Republican-controlled states to expand Medicaid at the time and was one of four states to use a 1115 waiver to implement state-mandated modifications to the federal plan.

Michigan provides for an interesting case study due to several historical and contextual factors, along with the varied measures taken by the state in response to the ACA. A strong union foothold led by the United Automobile Workers contributed to highly competitive salaries and benefits that were among the best in the country for the industry. Over time, however, jobs began to be outsourced and factories closed. By the mid-1970s, it had become clear that Michigan, like the rest of country, was entering a period of post-industrialization (Bell 1976). By the late 1990s, private-sector unionization had shrunk to levels equal to the early 1930s and the Great Depression (Moody 1997). The decline in unionization was a direct result of the shrinking labor market and disappearing workforce (Moody 1997).

Like many states in the same situation, Michigan's response to the ACA was greatly influenced by partisanship and third-party actors. However, unlike other states, the lines were less clearly strictly along partisan ranks. There were several conflicting supportive and oppositional measures taken by state leadership. The attorney general and governor took vastly different positions on the ACA, resulting in the state becoming party to several lawsuits while at the same time attempting to expand Medicaid and create a state run-exchange. There were also a number of third-party actors, interest groups, and Tea Party influences that further shaped the debate over the initial implementation in Michigan.

Lawsuits

The ACA was signed into law on March 23, 2010. Michigan Attorney General Mike Cox joined a federal lawsuit on that very day, along with 13 other states and the National Federation of Independent Business (NFIB), challenging the constitutionality of the individual mandate and the Medicaid expansion. Cox stated that it was in an effort "to stop President Obama and Congress from forcing Americans to buy a product as the price of citizenship" (Sellek and Yearout 2010). In addition to Attorney General Cox, the Thomas More Law Center in Ann Arbor also filed suit on behalf of Michigan residents. Counsel Robert Muise echoed the attorney general's comments, stating that "Congress has authority to do any number of things to improve health care. But the Constitution limits Congress to what it can impose on individuals. We

are here because the Congress violated the U.S. Constitution by forcing individuals to engage in a commercial activity" (Guthrie 2010).

The two lawsuits set the stage for the divide that would characterize the early implementation of the ACA in the state of Michigan. Attorney General Cox's decision to join the NFIB lawsuit began a bitter divide that would play out in Lansing and across the state over the coming months. At issue was whether Cox had the authority within the state to join the suit. Cox, a Republican, signed on to the NFIB lawsuit without the approval and support of Governor Jennifer Granholm, a Democrat. With the lines drawn, a power struggle ensued between the attorney general and the governor, both of whom were trying to promote their agenda before being term-limited out of office in 2011. Granholm acknowledged that there was little she could do about Cox's participation in the suit, and she proceeded to move forward by signing an executive order authorizing the creation of The Health Insurance Reform Coordinating Council (Jones 2014).

Both Cox and Granholm left office in early 2011. Cox was replaced by fellow Republican Bill Schuette, and Granholm was succeeded by Republican businessman Rick Snyder. Surprisingly, little changed; Schuette maintained support for the NFIB lawsuit that was working its way through the courts, and Snyder continued Granholm's support of health-care reform.

The suit brought by the Thomas More Law Center was first to be resolved and the first court decision on the constitutionality of the law across the country. At issue was whether the federal government could mandate citizens to obtain health coverage and penalize those who failed to do so. After deliberation, U.S. District Court Judge George Steeh upheld the primary challenge under the Commerce Clause of the U.S. Constitution. In support of the decision, Steeh stated that "the minimum coverage provision, which addresses economic decisions regarding health care services that everyone eventually, and inevitably, will need, is a reasonable means of effectuating Congress's goal [to address growing costs and increase coverage]" (Pelofsky 2010). The Thomas More Law Center was unsuccessful on appeal to the Sixth Circuit Court of Appeals and was denied review by the Supreme Court in July 2012.

Medicaid Expansion

After the NFIB ruling reaffirmed the constitutionality of the ACA and President Obama won reelection that fall, the debate within Michigan began to turn to what to do about Medicaid expansion. The question of whether to expand generally followed party lines with Democrats mostly in support and Republicans against expansion. The major exception was Republican Governor Rick Snyder. After the Court's ruling in the NFIB case, Snyder released a statement criticizing the ACA, stating that "the health care law fails to make important reforms needed in our health care system, has been a serious detriment to our economic recovery, and imposes significant new taxes on businesses and the American people" (Snyder 2012). Despite his voiced displeasure, Snyder

went on to state that it was his responsibility to move forward with expansion as soon as possible to ensure Michigan would be best able to take advantage of expiring federal funds and retain as much creative institutional control as possible.

Multiple legislative sessions were held during which third-party groups clashed over the best way to move Michigan forward. Several business advocates, including the Michigan Chamber of Commerce and the Small Business Association of Michigan, came out in favor of expanding Medicaid to control the state's response to the legislation (Eggert 2012b). Despite the formal unified support from the business community, the testimony of several outspoken Tea Party advocates seemingly had a greater impact on legislators' decision to vote down the bill. Local Tea Party member Isabelle Rockford argued that the law "is hugely expensive and puts the country on a horrifying path to financial ruin" (Eggert 2012b). At least in this initial committee session legislators agreed, voting down the bill on a five to nine vote with just two Republicans voting in support.

After the initial "no" vote, additional sessions were held and legislative leaders were eventually able to reach a compromise. By framing the issue as one of reform, not expansion, legislative leaders were able to accumulate the necessary votes to pass in both the state house and senate (Fangmeier, Jones, and Udow-Phillips 2014). On April 1, 2014, Michigan became the 24th state to expand Medicaid under the ACA, offering coverage to more than 440,000 Michiganders (Families USA 2016). Despite the vote of support, the decision was a combative one throughout the state. In a compromise of sorts between the Republican Governor Rick Snyder (in favor of expansion) and Republican legislators (split with a strong Tea Party opposition), and with approval from the Centers for Medicare and Medicaid Services, Michigan expanded Medicaid through a Section 1115 demonstration waiver on April 1, 2014. The demonstration waiver was the first of a two-part waiver process that provisionally expanded Medicaid within the state, while providing a termination clause requiring the program to be self-sustaining. The clause requires state savings to offset the state's required matching contribution beginning in 2017. Early analysis projects the state savings to continue through 2020 when Michigan will be responsible for 10 percent of total expansion costs (Snyder 2013).

Michigan's use of the Section 1115 waiver effectively allowed the state to take further control of the statewide Medicaid expansion process. The waiver was used as a compromise that appeased Republicans who had resigned themselves to the law's standing, and viewed the waiver as a control and a possible "check" should the system not be able to support itself financially. Democrats (and Republican Governor Snyder) viewed the waiver as a measure with which they could further customize the implementation of the law and Medicaid Expansion. Both Republicans and Democrats had some familiarity with the waiver as prior leadership had utilized a similar process to expand coverage to needy adults (Musumeci *et al.* 2017).

State Exchange

The decision over how to implement and administer the law was once again hotly contested. Governor Snyder advocated for a state-run exchange in order to retain as much autonomy and control over the process as possible. Attorney General Bill Schuette was adamantly opposed to Snyder's proposed state-run insurance exchange. Schuette urged law makers not to rush into creating an exchange. He warned that the law may still be overturned, minimalizing concern over expiring federal funds by stating that federal deadlines are often extended and are "as phony as a three-dollar bill" (Eggert 2012a). After the Supreme Court ruling and President Obama's reelection, House leaders took up the issue.

The Michigan State Senate voted in favor of creating a state-run exchange in the fall of 2011, with half of the Republican senators voting in support. At least partially due to Schuette's urging, the house failed to address the issue until the following year after the presidential election. All the while, there was a looming deadline of November 15, 2012 that would have to be met in order to qualify for federal funding. President Obama won reelection on the night of November 6, leaving little more than a week for the bill to pass the house to secure federal funding. At this point, there was growing Republican support for a state exchange as a way to reduce federal involvement and tailor it to the needs of the state. However, when the bill was introduced in the house, it was "tie-barred" to another controversial bill banning abortion coverage; meaning to support a state-run exchange would also ban abortion coverage under the new law. This was a tactical maneuver by hold-out Republicans that brought additional scorn from the Planned Parenthood Advocates of Michigan and ultimately torpedoed the bill within the Health Policy Committee (Fangmeier, Jones, and Udow-Phillips 2014). Republican House Speaker, Jase Bolger stated that there were simply "too many unanswered questions for the committee to feel comfortable with a state-run exchange" (Bouffard 2012).

Expressing disappointment, Snyder quickly moved to file paperwork creating a state partnership exchange to comply with federal funding deadlines. In a letter to Department of Health and Human Services Secretary Kathleen Sebelius, Snyder outlined his plan for the state-federal partner exchange. Snyder stated that Michigan would "perform the plan management function of a partnership exchange, as well as the consumer assistance function," with the additional responsibilities to be determined at a later date (Snyder 2013). Presently Michigan is one of 31 states running on a federal exchange.

Summary

The case of Michigan highlights the complexity and divisiveness that has taken place across the country as states attempted to institute mandated changes to health-care policy and delivery. Prior to the passage of the ACA, Michigan had nearly 40 percent of its population either uninsured or receiving

some level of subsidy. From the beginning, the debate was partisan and vitriolic with the Democratic Governor opting for expansion while the Republican Attorney General was entering the state into multiple lawsuits challenging the constitutionality of the ACA. The debate was far from over when new leadership took over each post in 2011. Perhaps the biggest surprise was Republican Governor Rick Snyder succeeding Democrat Jennifer Granholm, yet upholding her efforts to support the law. Despite the Governor's approval a vast divide remained.

Republicans framed the debate as one of fiscal responsibility, for not wanting to be on the hook for future cost increases should the system prove unsustainable. The Democrats attempted to compromise by selling the idea of being able to craft the implementation of the law in a way to minimize state risk and maximize coverage. Ultimately, the Democrats prevailed, but not before a long and protracted argument between the two parties and several other constituents including Tea Party representatives, the local business community, and Planned Parenthood all had a chance to weigh in.

There were few states nationwide as divided as Michigan was on how to respond to the ACA, where the attorney general filed suit and joined several others challenging the constitutionality of the law against the wishes of the governor. In the end, over the course of multiple years, compromise was achieved and a path forward set, through the use of Section 1115 demonstration waivers. The waivers gave supporters the promise of increased design, flexibility, and control, while opponents clung to the "exit" opportunity provided by the waivers, should revenues fall below the agreed upon level. The case of Michigan highlights the complexity that is inherent in policy design and implementation. Unlike many states where there was a general consensus on support or opposition, Michigan was clearly and equally divided with several factors influencing the final outcome. It is for these reasons that make the study of Michigan so interesting and informative.

California

California is geographically the third largest state in the country, but has the largest population in the nation with 28 million. California is also very diverse and is one of the few states with a minority majority, having equal populations of Caucasians and Hispanics, and a foreign-born population of 25 percent. Compared to the rest of the country, California residents are fairly healthy and rank among the five lowest states in the categories of smoking, obesity, and physical inactivity (Kaiser Family Foundation 2015a).

Unlike many other states, California residents demonstrated a great deal of support for the ACA when President Obama signed the legislation in 2010. This support has increased over time from 52 percent in 2010 to 62 percent in 2015, and opposition decreased from 38 to 33 percent between 2010 and 2015 (Seipel and Calefati 2015). The combination of left leaning politics in the state

and support from citizens has allowed California to be more progressive in their enactment of the ACA, which is reflected through their roles in the NFIB lawsuit, the implementation of their insurance exchange, Covered California, and their approach to Medicaid Expansion.

Lawsuits

As 25 states challenged the constitutionality of the individual mandate and Medicaid expansion components of the ACA, California was one of 13 states filing amicus briefs in support of the measures. On behalf of the California Endowment, a California-focused health foundation, Kathleen Sullivan filed the first brief on October 28, 2011 (PR Newswire 2012). Sullivan later filed a second brief to strengthen the data provided in the first brief. The California Endowment focused on two main points in its briefs. The first point argued that the minimum coverage requirement is connected to commerce because uninsured Californians are more likely to use expensive emergency rooms for routine care or go without medical attention due to high costs than insured Californians. Therefore, the minimum coverage requirement should be permitted under the authority given to Congress by the Commerce and Necessary and Proper clauses in the Constitution. Second, the California Endowment made the argument that key components of the ACA, increasing health insurance and reducing costs, could not work without the minimum coverage requirement. California had the largest number of uninsured residents in the country, and Sullivan argued that the ACA would be 54 percent less effective if the minimum coverage requirement was not upheld, resulting in 1.4 million Californians without insurance (PR Newswire 2012).

State Exchange

California took a largely bipartisan approach to the implementation of the ACA, which helped California become the first state to pass legislation creating a market exchange after the enactment of the federal health reform bill. On September 30, 2010, Arnold Schwarzenegger signed two bills establishing the California Health Benefit Exchange, becoming the first Republican governor to endorse the ACA (Benen 2010). In 2011, Democrat Jerry Brown took over the governorship and continued the progress started by Schwarzenegger by calling a special legislative session in 2012 to draft additional supplementary legislation to implement the ACA in California (Kaiser Family Foundation 2013a). California wanted to be a model for other states implementing the ACA. Diana Cooley, chair of Covered California and the secretary of California Health and Human Services, urged California state policy makers to make California the "lead car" in the implementation of the state exchange (Weinberg, Kallerman, and Carhart 2014).

Despite the initial cooperation of Republican and Democratic policy makers during the implementation of the Market Exchange in California, tensions rose in 2013 when President Obama gave states the option to extend individual

insurance policies for 2014. In California, the five-member board of Covered California voted unanimously to continue enrolling individuals into new health-care plans, refusing to extend the insurance deadline to 900,000 individual insurance policyholders. This decision yielded mixed responses, even within the Democratic Party. Board members were accused of protecting insurance companies instead of citizens. Despite the discontent by a few, many policy makers felt that refusing the extension was the right call. Senate President Pro Tem Darell Steinberg justified the decision due to the success California was experiencing in their ACA implementation. With the option of several competitive plans, more than 100,000 people were enrolling in Covered California daily, the highest rate of any state in the country. Diana Dooley, Secretary of the California Health and Human Services Agency, also defended the decision made by Covered California arguing, "[i]f we ask the insurance plans to take everybody and insure everybody with no screens or pre-existing conditions then we have to have everyone buying some level of health insurance to meet their responsibility to the system" (Seipel and Calefati 2013).

Medicaid Expansion

California formally voted to expand Medicaid in June 2013, which would have allowed individuals to enroll in Medi-Cal in 2014. In 2010, however, California became one of six states to take advantage of a Medicaid 1115 waiver allowing California counties to expand coverage to low-income adults in 2011 (Kaiser Family Foundation 2015b; New York Times 2013). The 1115 waiver, referred to as the California Bridge Reform, began on November 1, 2010 and allowed California to receive $10 billion in Federal funds over five years (Western Center on Law and Poverty 2011). Many California counties utilized the 1115 waiver funds by creating low-income health plans (LIHPs) in preparation for Medicaid expansion. Once Covered California and Medi-Cal were available, individuals would transfer from their county's LIHPs to the program they were eligible for. Although the decision to expand Medicaid happened quickly and with little debate, California Republicans did voice concerns over the ability of the state to afford Medicaid expansion in the long run. Democrats argued that without the Medi-Cal program, California taxpayers and those with insurance would continue paying for the medical care of those without insurance. To ease concerns, Democrats included provisions that would allow policy makers to revisit expansion legislation if the funds contributed by the federal government fell below 70 percent (New York Times 2013).

Summary

Overall, California has met their goal of becoming one of the ACA implementation leaders in the United States. California provided insurance to millions, while maintaining profits for insurance companies and health-care companies. California has also accepted and used federal funds effectively, which has allowed communities to extend insurance to the uninsured quickly.

California's success was achievable due to bipartisan cooperation and support from California residents, which allowed legislation to be enacted and implemented quickly.

New Hampshire

The northernmost original colony, New Hampshire is bordered to the north by Quebec, Canada; to the east by Maine; to the south by Massachusetts, and to the west by Vermont. New Hampshire is currently one of the least populated states in the union and is also one of the smallest states by land mass. Although small in size, New Hampshire enjoys a high median annual income (Kaiser Family Foundation 2015a). New Hampshire has a long history of political traditions in which the town became the most important element of community organization after the family. These original settlers formed towns to ensure effective governance, to promote committed social organizations. These community-building efforts and traditions were the foundation for the long-standing political traditions still found in contemporary New Hampshire (Daniell 1981).

One of New Hampshire's most cherished political traditions is the concept of limited government. New Hampshire has a long-standing belief that government should be minimally involved in day-to-day activity, and the market should be the driving force behind policy decisions. If there is no other alternative than government interaction, it is at the most local level that citizens of New Hampshire prefer action, rather than at the state or federal level. This sense of local governance still permeates policy decisions today in the Granite State. It is in this manner that New Hampshire responded to the ACA. While Republicans in New Hampshire were overwhelmingly opposed to the ACA in any form, Democrats supported implementing health-care reforms as long as they were in terms that met New Hampshire's tradition of fiscally conservative limited government (Rockefeller Institute 2015).

Initially, Governor Lynch, a Democrat, tested the water for support of the ACA, but the state's conservative law makers were unanimous in their opposition. Stating that the ACA's framework of federal mandates clashed with New Hampshire's culture of limited government, the legislature overwhelmingly pushed back against any support. Knowing he had little support, Governor Lynch put a one million dollar grant on the legislative agenda to fund the implementation of a state exchange. State legislators demonstrated their opposition by countering with legislation that limited the amount the state may accept from the federal government. The legislators cut the funding to a level that was too low to begin a conversation about an exchange, effectively vetoing the exchange without actually voting against it. As a result, the State Insurance Department declined to work with the limited funding resulting in the discussion on creating a state exchange being tabled (Langley 2011). The legislature went on to pass HB 1297, which outlawed the creation of a state exchange and

permitted limited state involvement in any exchange within New Hampshire. Additionally, the state legislature passed a second bill in direct opposition to the act prohibiting the individual mandate and its associated penalties from affecting New Hampshire citizens (New Hampshire Legislature 2012; Rockefeller Institute 2015). It became increasingly clear that the basic foundation of the ACA, which mandated federal involvement, was contradictory to New Hampshire political traditions and was going to make any advancement of the bill difficult. Without a skilled statesman providing a sense of externality that allowed New Hampshire to keep their political traditions while still providing health care for those in need, the ACA would continue to meet stiff resistance.

The citizens of New Hampshire have been highly skeptical of the ACA. Initially New Hampshire chose not to create a state exchange and then took it one step further, passing legislation prohibiting a state-based exchange. They also chose initially to not expand Medicaid, and passed legislation opposing mandated coverage and associated tax penalties. However, in 2014 the New Hampshire legislature worked across party lines and was able to create a Medicaid Expansion plan under a private option that the federal government approved under a waiver. This private option allowed New Hampshire citizens to accept expanded Medicaid funds to be used to purchase private health insurance. This compromise allowed New Hampshire legislatures to give the appearance of limited government while allowing almost 150,000 uninsured New Hampshire citizens access to health care.

State Exchange

HB 1297 prohibits the state from running the health exchange, but it left the door open for the state to perform specific functions associated with the federal exchange. After steadfast resistance to the creation of a state exchange supported by legislature that outlawed the creation of any state exchange, New Hampshire defaulted to the federal exchange and put implementation under the guise of the New Hampshire Insurance Department (NHID). This created a federal-state partnership of sorts, with the state holding responsibility in administering the federal exchange. Legislators purposely kept the task of implementation as a secondary or tertiary duty of the NHID staff with the intent of slowing the development of the exchange. Only the bare necessities were outsourced to create the minimal framework necessary to be in compliance with the law. Additionally, NHID turned down several million dollars in federal grants to promote the exchange locally, once again to exert their opposition to federal involvement in what was seen as New Hampshire's business. The management arrangement allowed state-level manipulation of the federal process (Kaiser Family Foundation 2013b; Rockefeller Institute 2015). When the exchange was implemented in 2013 Anthem Blue Cross and Blue Shield was the sole provider of health insurance in the New Hampshire market. While complying with the federal minimum standards, the lack of competition resulted in some of the highest premiums in the country (Kaiser Family

Foundation 2013b). Since then two others providers, Harvard Pilgrim and Minuteman, have begun offering coverage through the exchange (Sanders 2017).

Medicaid Expansion

Consistent with New Hampshire's tendency to avoid any policy choice involving increased federal government participation, they were among the states that chose not to initially expand Medicaid. However, in 2014 Governor Hassan, a Democrat, was able to craft a plan that pleased legislators on both side of the fence. Hassan's private option took federal dollars to buy health care through a private health insurance provider for those uninsured citizens who met the criteria. Centene Corporation created Ambetter Health for the sole purpose of servicing the needs of those who entered the market through Medicaid expansion (Sanders 2017). Framing the expansion in such a fashion allowed a sense of political externality, in that New Hampshire could provide insurance for its deserving citizens and still have the sense they had not "caved in" to Obamacare. Framing the proposal so as to stay within the guidelines of New Hampshire citizens' thirst for limited government involvement resulted in broad bipartisan support. Another key component was the sunshine provision, included to cease involvement when federal funding reduces from 100 percent (Kaiser Family Foundation 2015a; Rockefeller Institute 2015).

State Legislation

New Hampshire's state legislature passed at least three bills aimed at obstructing implementation of the ACA. Staying true to the traditions of the Granite State's ideology and traditions of limited government and "free market policy solutions" (Rockefeller Institute 2015, 19) while still allowing some wiggle room for the state's uninsured to benefit from the coverage the ACA provides. A deep partisanship and opposition to the ACA slowly eroded as legislators found ways to provide coverage to those in need while still framing their policy decisions to conform to the culture of the state. New Hampshire's compromise plan allowed anti-Obamacare conservatives to implement a system that allowed 92,000 residents to acquire coverage through the marketplace and Medicaid expansion.

Summary

The fiscally conservative political traditions, along with the strong Republican opposition to the ACA, resulted in New Hampshire's "wait-and-see" approach to any initial decisions in support of the ACA. The flexibility of the ACA afforded New Hampshire the opportunity to exercise Medicaid expansion through the private option. This option allowed New Hampshire to maintain the outward appearance of being in opposition to Obamacare while affording the citizens of New Hampshire the expanded health-care coverage of the ACA (Rockefeller Institute 2015).

Analysis and Discussion

The cases presented in this article illustrate the wide array of unique state factors that led states to support or oppose the ACA. While 50-state studies indicate the importance of partisan Republican control of state government (particularly the governor's mansion; see Barrileaux and Rainey 2014; Mayer, Kenter, and Morris 2015), our research suggests the underlying processes in the states are more subtle and nuanced. In Alabama, for example, a Republican governor seemed initially supportive of the ACA, but as nationwide opposition grew, the governor's position began to change. Moreover, the governor's waning support can be linked to concerns over the viability of the health insurance market in the state.

Likewise, state support or opposition to Medicaid expansion was driven by several factors; partisan political control represents but one of those factors. California's democratically controlled legislature accepted Medicaid expansion, but in an effort to placate Republicans, agreed to include language in the legislation that allowed the state to revisit the decision if it appeared that costs were above estimates. The compromise plan struck in New Hampshire was of a different sort, but fit the specific values, culture, and concerns of New Hampshire legislators. The California approach would not have worked in New Hampshire, and vice versa. Both the Michigan and New Hampshire cases suggest that partisanship alone cannot explain state choices.

The debates over state insurance exchanges follow a similar theme. In Alabama, concerns over the lack of qualified insurance companies to compete in a state exchange were a major driver of the decision for the state to abandon plans to create a state exchange. Michigan's process was driven in part by disagreements between the attorney general and the governor. Although a bill to create a state exchange passed the state senate with bipartisan support, the house bill tied the state exchange to an abortion issue. Unable to separate the two issues, the bill ultimately died, forcing the governor to file paperwork for participation in the federal exchange. In this case, the outcome of an ACA-related implementation decision was determined by an unrelated policy issue.

The cases also illustrate a great deal of uncertainty on the part of state policy makers. While California moved quickly to implement the ACA, concerns about whether the ACA would survive challenges in the Supreme Court, or a potential change in the presidency in the 2012 election, had something of a paralyzing effect on some states. In other states, such as Alabama and Michigan, the governors, attorneys general, and legislatures had diverging interests and positions on the ACA, which led to independent action rather than coordinated state action. In many states, the attorney general is elected in a statewide election, and can operate quite independently of the governor or the state legislature. Even if the offices are held by members of the same party, policy disagreements can have a significant impact on state policy choices—a situation likely to be overlooked in a 50-state analysis.

In terms of policy analysis, this situation presents something of a conundrum for scholars conducting 50-state analyses of state policy choices. There is often an assumption that states arrive at a clear consensus on a policy decision, and that the factors that drive the decision are equally important (and equally important to all actors in all states). Our research illustrates the inherent limitation of such an assumption. Although we do not deny the utility of quantitatively based 50-state comparative studies, we must be cognizant of the inherent limitations of such an approach. If Dror's (1968) description of states as "policy laboratories" is indeed accurate, then we should expect a rich array of context-specific factors to be found behind the more coarse variables chosen for quantitative analysis.

Utilizing the state policy choice framework and the case study approach, we are able to build on the work and findings of prior 50-state policy analyses (see Barrileaux and Rainey 2014; Mayer, Kenter, and Morris 2015). The case study approach highlights internal divisions; even at the policy extremes, and how the decision-making process was not as cut and dried as some would argue. The use of the framework allows for comparison and discussion of state needs and how they differ as highlighted above and throughout this article. Further, the study allows for comparison and perhaps more importantly highlights where and why states diverge in their decision-making process.

Conclusion

Our research sheds additional light on the decision processes of states as they pertain to initial implementation of the ACA. Our cases are illustrative of states at the extremes of the level of support or opposition, along with a state in the middle of the range and a state that exhibited the greatest degree of policy change in the early years of implementation. Our analyses suggest that the forces behind state decisions go beyond partisanship, and include state policy priorities, the degree to which state policy makers share a general agreement about policy goals, and the ability of state policy makers to reach a consensus. All of this takes place in the broader context of a national policy debate, which in turn influences individual state choices.

As of this writing, the future of the ACA is uncertain. The president and leaders in Congress have vowed to repeal the ACA, but have yet to devise a plan capable of garnering enough votes in Congress to become law. Indeed, recent attempts in the Senate to repeal and replace the ACA have failed to amass enough support to move forward. In either case, the ACA presents an opportunity for scholars to examine state implementation of complex national policy at a common point in time. Because the national legislation contained deadlines for state action, all states were required to make decisions at more or less the same point in time. This study limits its scope to four states, but further research is needed to determine whether the themes detected across these four states are present in other states. To the extent these themes are present

elsewhere, they may provide a foundation for a more complete understanding of not only the implementation of the ACA, but of similar policy initiatives.

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