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Have the ACA's Exchanges Succeeded? It's Complicated

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Abstract

The fight over health insurance exchanges epitomizes the rapid evolution of health reform politics in the decade since the passage of the Affordable Care Act (ACA). The ACA's drafters did not expect the exchanges to be contentious because they would expand private insurance coverage to low- and middle-income individuals who were increasingly unable to obtain employer-sponsored health insurance. Instead, exchanges became one of the primary fronts in the war over Obamacare. Have the exchanges been successful? The answer is not straightforward and requires a historical perspective through a federalism lens. What the ACA has accomplished has depended largely on whether states were invested in or resistant to implementation, as well as individual decisions by state leaders working with federal officials. Our account demonstrates that the states that have engaged with the ACA most consistently appear to have experienced greater exchange-related success. But each aspect of states' engagement with or resistance to the ACA must be counted to fully paint this picture, with significant variation among states. This variation should give pause to those considering next steps in health reform, because state variation can mean innovation and improvement but also lack of coverage, disparities, and diminished access to care.

Keywords Affordable Care Act, health insurance exchanges, federalism

The fight over health insurance exchanges epitomizes the rapid evolution of health reform politics in the decade since the passage of the Patient Protection and Affordable Care Act (ACA). The ACA's drafters did not expect the exchanges to be contentious but, rather, saw them as "a conservative means to a liberal end" because they would expand private insurance coverage to low and middle income individuals who were increasingly unable to obtain employer-sponsored health insurance (Jones, Bradley, and Oberlander 2014: 103). The exchanges were supposed to be set up by states to facilitate competition among commercial insurers by stimulating the

individual and small group insurance markets. Instead, exchanges became one of the primary fronts in the war over Obamacare.

Most of the individual elements of the exchanges—insurance regulation and consumer protections, pooling the uninsured together to give them greater purchasing power, income-related subsidies to help people with modest incomes afford coverage, a standard benefit package, and choice among private insurance plans—were not controversial.¹ Versions of these ideas had been included in health reform proposals by prominent Republicans such as Richard Nixon, George H. W. Bush, Mitt Romney, and Paul Ryan. Yet, the Obama administration faced a surprising degree of resistance, namely, from Republican leaders, when it came time to implement the exchanges.

Have the exchanges been successful? The answer is not straightforward and requires a historical perspective through a federalism lens. What the ACA has accomplished has depended largely on whether states were invested in or resistant to implementation, as well as individual decisions by state leaders working with federal officials. Cross-state comparisons show adopting

¹ In addition, new federal rules established consumer protections such as essential health benefits that all qualified health plans must cover to be sold on an exchange, including services commonly excluded in the pre-ACA individual market, such as maternity care, mental health care, and pediatric dental services. Qualified health plans also could not impose annual or lifetime limits or exclude those with preexisting conditions. Plans were to be kept affordable through community rating, a 3:1 rating band, cost-sharing reductions, and premium tax credits that fluctuate based on individual income and the price of benchmark plans. Plans were also standardized across four “metal” tiers of actuarial value.

a suite of policies designed to reduce the uninsured rate—such as investing in outreach, establishing a state-based exchange, and Medicaid expansion—resulted in stronger insurance markets. But these options rely heavily on local political will.

We begin by highlighting how and why states made key decisions; then we discuss the metrics that should be used to evaluate the impact of the exchanges. These two sections lead to the conclusion that the exchanges have been least impactful in the states that used the exchange as an opportunity to oppose the law’s existence and most successful where leaders cooperated with the Obama administration—or at least got out of the way. We conclude by considering the future of the exchanges in the next chapter of health reform.

Fifty Reenactments of the ACA Fight

The Obama administration’s central goal for the ACA was to move toward universal coverage with at least some bipartisan support. Developments at the state level suggested that exchanges were an important component of a bipartisan strategy to achieving that goal. Ed Haislmaier (2006) of the Heritage Foundation said of the 2006 Massachusetts health reform—largely constructed around the first statewide insurance exchange—that governors and legislators would be “well advised to consider this basic model as a framework for health care reform in their own states.” Utah, one of the most conservative states in the country, followed this blueprint and passed Utah H.B. 188 in 2009 to create an exchange for small businesses, with 96.3% of Republicans voting in favor. Polling suggested that more than half of Republicans supported the idea of providing tax credits to help people buy insurance in a state-based exchange (KFF 2010).

Yet, by the time open enrollment began for the ACA in October 2013, 34 states had rejected control of their exchange.

For many reasons, giving states a major role in the creation of exchanges seemed like a good idea, including that the ACA might not have been enacted any other way. When the bill that ultimately became the law passed the Senate on December 24, 2009, Democrats had exactly 60 seats, meaning they could not spare a single vote and still overcome the threat of a Republican filibuster. Relying on the joint federal/state governance of federalism gave conservative Democrats a response to anyone describing the bill as a national government takeover. However, Scott Brown's election in Massachusetts a few weeks later meant that Democrats had lost their filibuster-proof majority, and passing the bill in December with state-based exchanges was the only path to enacting health reform.

Tim Jost was correct when he warned in 2009 that giving states a prominent role in implementation would open the door to 50 reenactments in state capitals of the fight Congress had just experienced (see Jost 2010). Federalism was a political pressure-release valve that made enactment possible but also dramatically complicated the politics of implementation. The law's drafters assumed that virtually every state would adopt at least a bare minimum approach to implementing its own exchange and that blue states would use their flexibility to innovate beyond the ACA. Initially, conservatives seemed to see things the same way: in 2010, 49 states began planning for a state-based exchange, including applying for and receiving \$1 million federal planning grants and running local stakeholder engagement processes (Jones 2017).

Immediate Complications in Implementation

The 2010 election was the first milestone in the fight over the exchanges and the ACA's implementation. The growing Tea Party movement focused on gubernatorial and state legislative races, successfully turning blue states red and making red states redder, shifts that signaled ACA implementation might be tested. But even then, it would have been difficult to predict the intensity of opposition that would soon be leveled against the ACA and the assumption that states would want to run their own exchanges. Yet, despite the common narrative of Republicans opposing President Obama, the main partisan split in many states was not between Republicans and Democrats but within the Republican Party (Jones, Bradley, and Oberlander 2014).

Kansas offers a dramatic example of the Republican evolution. The outgoing governor was a Democrat, whose administration applied for a \$31.5 million grant to be an innovator state in developing an exchange (Jones 2017). By the time the Department of Health and Human Services (HHS) considered the state's grant application in late 2010, Republican Sam Brownback had been elected governor but had not yet taken office. Brownback vehemently opposed the ACA's passage as a US Senator, and HHS wanted assurance that if they awarded Kansas the money, he would not get in the way. Governor Brownback promised HHS that Kansas would implement the ACA and be a lead exchange development state (Jones 2017).

Governor Brownback spent the first half of 2011 defending his decision to conservative groups, who felt betrayed by his cooperation with the Obama administration. He argued that, although he supported the lawsuit challenging its constitutionality, the ACA was still the law of the land. Taking money from the Obama administration was a subversive act to implement Obamacare "the Kansas way." Tea Party activists in his state and across the country disagreed. In August 2011, Governor Brownback's chief of staff and nearly a dozen Republican legislators from Kansas attended the annual meeting of the American Legislative Exchange Council

(ALEC) in which Ed Haislmaier—who had described Governor Romney’s law in Massachusetts as a blueprint for states to follow just five years earlier—argued that the exchanges were a frontline for opposing Obamacare. He called for “house by house, floor by floor, room by room combat” on Obamacare (Mooney 2011). Days later, Governor Brownback announced he was rejecting the HHS grant and would not build an exchange.

The year 2012 was similarly tumultuous in the fight over health insurance exchanges across the country. Some Republicans signaled they were open to creating a state-run marketplace but preferred to wait until the Supreme Court ruled in *NFIB v. Sebelius*. They did not want to undermine the lawsuit that many of them had supported and did not want to devote resources to implementing a law that they hoped would be invalidated. The Court’s June 28 decision upholding the constitutionality of the individual mandate came one day before HHS’s deadline for states to apply for the major grant to build information technology infrastructure in time for the start of open enrollment in October 2013. The Obama administration moved the deadline back to November, hoping that more states would pursue an exchange. But leaders in red states decided to wait until after the 2012 election, hoping Mitt Romney would be elected and follow through with his promise to undo the ACA. By the time election occurred, many leaders felt it was too late or refused to implement exchanges as an act of resistance galvanized by the Court’s rendering Medicaid expansion optional. For most, the decision to delay had become a de facto decision to default to the federal exchange (Jones 2017).

Who Gets to Decide?

In many states the decision over whether or not to create an exchange came down to a fight over who decides. Seemingly mundane features of institutional design shaped the power dynamics between key players. For example, the New Mexico legislature meets for only 2 months every year and must focus in even-numbered years on the budget and bills introduced by the governor. Though states had more than 3 years to set up an exchange, the New Mexico legislature effectively had only brief windows in 2011 and 2013 to make this decision. New Mexico passed enabling legislation in March 2013, but the first decision of the newly created exchange oversight board was to default to the federal website because no time remained to develop state-specific technology.

Similarly, 10 states have insurance commissioners that are independently elected rather than appointed by the governor (Morton 2013). Mississippi's insurance commissioner, Mike Chaney, did not support the ACA but believed Mississippi would be in a better position if its exchange was regulated at the state level. Mississippi Governor Phil Bryant initially stayed out of the way, and HHS indicated it would work directly with Chaney. However, Bryant bowed under Tea Party pressure and threatened that his Medicaid agency would refuse to cooperate with the insurance department's exchange. The Obama administration reluctantly sided with Bryant, making Mississippi the only state to have an application for a state-based exchange rejected by the federal government (Jones 2017).

The need to fight on so many fronts was one important factor in the Obama administration's disastrous launch of HealthCare.gov on October 1, 2013, but many others contributed. This included the challenge of integrating databases from across multiple arms of government and a misguided reliance on Medicare.gov as a model for the website. But ultimately the site was launched successfully and became one of the centerpieces of the ACA. In the next

section, we investigate the evidence of exchange success by looking beneath national statistics to unearth the importance of state participation.

The Record to Date

The goal of the exchanges was to improve coverage, access, affordability, and quality of benefits while maintaining sufficient commercial insurer competition to drive value. Initial enrollment in the exchanges was considerably lower than early estimates predicted due to technological glitches with HealthCare.gov and state-based exchange platforms, as well as the unaffordability of coverage options for higher-earning groups. The ACA had envisioned states taking the lead in advertising during open enrollment and so had not allocated much money to the federal government for this purpose. Former members of the Obama administration started Enroll America to go door to door and sign people up for coverage in large states that had rejected control of their exchange, such as Florida, North Carolina, and Texas. The Centers for Medicare and Medicaid Services (CMS) had to take money from other ACA programs such as the Prevention Fund to pay for advertising.

Younger adults enrolled in coverage at lower rates than predicted, contributing to disappointing enrollment figures and risk pools that lacked healthier enrollees (Kliff 2014). By the end of 2013, politicians and pundits created a swirling sense that the exchanges were an impending disaster, with House Speaker John Boehner declaring he did not think the exchanges in particular and the ACA in general were “ever going to work” (Parkinson 2013).

Despite these dismal predictions, after a rocky start exchange enrollment increased and premiums were lower than predicted (Glied, Arora, and Solis-Roman 2015). Between 2013 and

2016, the portion of the total US population covered by nongroup private coverage grew from 3% to 7% (KFF 2017). This increase might seem modest, but one estimate suggests that nearly 40% of ACA-related coverage gains in 2014 were driven by the premium subsidies offered in the exchanges (Frean, Gruber, and Sommers 2016).

From 2016 to 2019, exchange enrollment slightly declined nationally. Considerable volatility in premiums arose as the Trump administration eliminated the cost-sharing reduction payments, slashed funding for enrollment assistance, and expanded access to ACA-noncompliant plans, and then Congress zeroed out the penalty for the individual mandate (KFF 2019). The exchanges have been remarkably resilient to these attacks due to strategic state responses and the enduring value of exchange coverage. For example, in response to the elimination of cost-sharing reduction payments, many states increased the price of their benchmark silver plan, a strategy known as “silver loading.” Because federal premium tax credits are calculated using the price of the second-lowest silver-tier plan, this strategy recouped the lost federal cost-sharing reduction payments in the form of tax credit dollars and helped to stabilize exchange markets.

Paradoxically, the elimination of the cost-sharing reduction payments has increased exchange enrollment and lowered premium costs for many low- to middle-income consumers (CBO 2018). In 2018, zero-premium coverage was available to over half of exchange enrollees (Branham and DeLeire 2019). In 2019, average premiums fell for the first time since the ACA was implemented, though prices have increased for higher-income consumers ineligible for federal subsidies (KFF 2019). More insurers entered the exchanges than exited in 2019, and nationwide, premiums are expected to decrease slightly in 2020 (Fehr, Cox, and Levitt 2018; Fehr et al. 2018; Scott 2019). The beneficial effects of silver loading may have weakened what could have been a series of fatal blows to the exchanges. Trump administration policies have put

the exchanges to an important test: without a mandate and with cheaper, skimpier plans just a click away, do consumers abandon exchange coverage? The evidence suggests many have decided to stay.

Yet national statistics mask significant state-level heterogeneity. Despite the federal policies designed to regulate the cost and quality of insurance options sold through the exchanges, variations in implementation efforts drive stark differences in coverage, access, competition, and affordability by state. The Supreme Court in 2015 could have dramatically raised the stakes of state decisions had it concluded in *King v. Burwell* that tax credits were available only in states that ran their own exchange. Even so, one study found that premium subsidies were nearly twice as effective at increasing health insurance coverage rates in states that opted to establish their own exchange rather than use the federal exchange (Frean, Gruber, and Sommers 2016). Larger effects of premium tax credits in states with local exchanges reflect a host of state-level factors that enhance take-up of subsidized insurance. States that run their own exchanges benefit from greater customization and the opportunity to integrate enrollment infrastructure efforts across state programs. Under state or state-federal partnership exchange models, states conduct marketing, outreach, and consumer assistance and run their own online eligibility and enrollment platforms.

State-run outreach efforts have become critical to stabilizing exchanges in recent years as the Trump administration drastically cut funding for open enrollment advertising and consumer assistance programs. In 2017, nearly 800 counties in states with federally facilitated exchanges did not have any federally funded navigation services (Galewitz 2018). In contrast, states that have state-based exchanges were able to supplant federal funding with local funds. In California, healthy risk pools and an above-average insurance sign-up rate are due in part to the state's

considerable expenditures on outreach (Corlette and Schwab 2018). State leaders elected in 2018 recognized the potential benefits of local exchange administration, as five additional states have indicated intent to transition part or all of their exchange infrastructure to the state level by 2020–22 (Schwab and Volk 2019).

Whether a state adopted Medicaid expansion is another important decision that effects the stability of exchanges, as expansion states were more likely than nonexpansion states to have more carriers participating in their markets, lower premiums, and healthier risk pools (Gabel et al. 2018; Semanskee, Cox, and Levitt 2016; Sen and DeLiere 2016; Han et al. 2015). This correlation may be due to Medicaid expansion offering an alternative source of coverage for individuals with greater health needs, which kept potentially higher-cost individuals out of state exchanges, Medicaid managed care organizations having more experience covering lower-income and higher-need populations, and less disruptive insurance coverage churn. State investment in Medicaid enrollment outreach also raised awareness of all insurance options, public and private.

Carrier participation also differs widely by region. In 2019, a third of rating regions had only one participating insurer, with the majority concentrated in southern, rural states with lower median incomes (Gabel et al. 2018). Markets with more competition offer enhanced consumer choice and lower premiums, which increases enrollment (Van Payrs 2018). However, insurers that have maintained financial viability in the exchanges have largely done so through selective contracting for lower rates with a narrow network of providers. Exchange plans with limited networks are a concern nationally, as limited provider options may impose barriers to timely access to care. Narrow networks are an even greater concern in rural regions where provider shortages already existed.

Despite the successes some states have experienced, exchanges have some shortcomings that impact all states. For example, affordability remains an issue nationally, with nearly half of exchange enrollees exposed to full cost sharing and nearly 90% of those in the exchanges enrolled in high-deductible health plans (Dolan 2016). Out-of-pocket prescription drug costs are double those of the average employee plan (Thorpe, Allen, and Joski 2015). Further, actuarial values represented by metallic tiers in qualified health plans are realized for only a small proportion of enrollees with enough health care spending for their insurer to pay their allocated portion of the costs. Because of this, most exchange enrollees pay for the majority of their care out of pocket (Polyakova, Hua, and Bundorf 2017). Again, states vary in their efforts to rein in premium costs, with 12 states establishing reinsurance programs through section 1332 state innovation waivers to encourage insurer participation, spur competition, and offer lower-priced plans to consumers.

While national- and state-level challenges exist, the exchanges still represent improvement relative to the unregulated, expensive, and inequitable insurance markets that existed before the ACA. The ACA was created to deal with high rates of uninsurance among low- to middle-income workers who were left out of private and public options, and the exchanges have created coverage where none existed. But was the political turmoil avoidable, or was it inherent in the federalism structure of the ACA? We explore these questions next.

Learning from the ACA and the Future of Federalism in Health Reform

The ACA was designed to foster near-universal insurance coverage, and its approach to that goal was to devise federal baselines above which states would operate. Federalism was a politically

pragmatic choice that seemed necessary to gathering votes for the law's passage and a structural governance choice that is often a default approach in American health reform. Federalism also predictably results in variability. While variation can translate into policy successes or failures, variation in health policy often leads to inequitable policy across states and disparities across populations.

States were supposed to run the exchanges because states historically have regulated insurance, but the ACA's implementation has been inconsistent with its statutory design. The political litmus test of resistance to the ACA, combined with opposition through litigation, has made it so the states that ordinarily prioritize their own sovereign lawmaking authority decided to reject federal policy, and federal power actually expanded within their borders through the federal exchange. The adaptive, negotiated, dynamic federalism that HHS and states engaged in to create something between the federal- and state-run exchanges was not the federalism of the ACA as enacted but developed organically as a response to implementation hurdles (Gluck and Huberfeld 2018). These negotiations have not reflected the Supreme Court's constitutional concern—that states could not fend for themselves—in striking down the Medicaid expansion as “coercive” in *NFIB v. Sebelius*. Rather, this dynamic federalism demonstrated states are adept at making demands and extracting compromises from HHS, learning from other states, negotiating, and finding a way to get a little more.

Our account of the exchange implementation dynamics illuminates that no federal health care takeover has occurred. Indeed, the unevenness of state exchange implementation may indicate that the federal law of the ACA does not go far enough in creating a strong national baseline, precisely because this variability has weakened the policy goal of universal coverage. Varying levels of success across states reflect the design of the federal law. But states' successes

and failures also reflect the negotiations that occurred to implement the ACA, which included state policy decisions to support or thwart the ACA at every stage. Notably, HHS Secretary Kathleen Sebelius and other officials in the Obama administration accepted state participation in many forms, regardless of the ACA's statutory design, so that hybrid and partnership exchanges also developed. These were not specifically contemplated by the ACA but arose in response to the political resistance to the law that was itself undermined by state insurance commissioners' and health care stakeholders' desire to see the law implemented. Perhaps most surprising, the vast majority of states have a hand in running the exchange in their own markets, whether or not they established any kind of state-based, partnership, hybrid, or other exchange.

So whether the ACA's new exchanges were successful very much depends on where one looks, as states both implemented and undercut the ACA during the Obama administration. Some states that tried to create their own exchanges failed, while other states that appeared hostile on the surface actually worked with the Obama administration behind the scenes. For example, both Oregon and Florida rely on the federal exchange platform, but their politics and policy desires have been very different, with Oregon reliably counting as "blue" (tried to create an exchange but failed) and Florida counting as "red" (never created its own exchange). In other words, the federalism story is much more complex than the standard account that two-thirds of states did not implement state-based exchanges. The fact of a state relying on the federal exchange does not begin to tell us everything about that state's engagement with the ACA or whether or why that state experienced significant increases in coverage.

Further, resisting creation of a state-run exchange was just one way that states undermined the ACA during the Obama administration. For example, we noted above that the interplay between exchanges and Medicaid expansion has been important. While nearly half of

the individuals who are uninsured could enroll through an exchange with federal tax subsidies, these remaining uninsured are living in Medicaid nonexpansion states—states that have resisted ACA implementation in all of its federalism dimensions. These ACA-hostile states have higher rates of uninsurance and poorer performance on the other metrics of health policy success. Yet, paradoxically, some states also worked with HHS to expand Medicaid and implement exchanges with state-specific names and special rules attuned to the politics of the state—though these were acts of state resistance to Obamacare (similar to Governor Brownback’s vision described above), ultimately such engagement helped facilitate the exchanges’ success.

The Trump administration made no secret of its hostility to the law; President Trump’s first executive order was a directive to limit the regulatory scope of the ACA. The administration took steps to thwart the ACA’s goal of universal coverage, such as cutting navigator funding, decreasing advertising for open enrollment, limiting the open enrollment period, and destabilizing the small markets of the exchanges by allowing short-term plans to be sold as ACA compliant. The administration has been undermining exchange enrollment while at the same time allowing states to create barriers to Medicaid expansion enrollment for the people newly eligible under the ACA, such as work requirements—again, the fate of the exchanges and Medicaid expansion have been intertwined.

Despite the challenging road to implementation and multiple legislative attacks, the exchanges have become a standard building block of the American health insurance architecture. In fact, the Republican replacement bills, such as the American Health Care Act of 2017, included the same basic framework of an exchange with consumer protections and premium tax credits. The House Republican bill did include important changes at the margins, such as increasing the rating band to 5:1 and tying premiums to age instead of income, but these were not

supported by Senate Republicans. And, these were not legally or structurally significant changes relative to what the ACA already created—a federalism-dependent, highly regulated, publicly supported insurance market.

Yet, the role of federalism in the success or failure of the exchanges is ultimately hard to measure, in part because states' policy choices have cut both ways. Some states undercut the law during the early years, leading to challenges to the law, such as *NFIB v. Sebelius* and *King v. Burwell*. States also limited the reach of the federal exchange by enacting nullification laws, which were of no legal consequence but contributed to public confusion about the ACA's existence. And states' refusal to engage with HHS publicly also undermined accountability for the exchange implementation, which made it harder for voters to know who was responsible for the law's successes and failures.

For all of this confusion and resistance, the nation's uninsurance rate at the end of the Obama administration was the lowest it had ever been, at 8.6% by some measures. While the exchanges do not cover a large percentage of the population, they provide subsidized access to insurance markets for those who have been stuck outside of both public and private insurance, playing a key role in expanding coverage for low-income and part-time workers.

Conclusion

The fight over health insurance exchanges over the last 10 years is a fascinating case study in what happens when preferences over policy and federalism conflict with partisan goals. Exchanges were initially a bipartisan idea that became ideologically charged only as they became wrapped in the broader party politics of Obamacare. After congressional Republicans

failed to block the ACA's passage, some of their state-level counterparts used their role in implementing the exchanges to attempt post enactment obstructionism that they hoped would unravel the entire law, even if it meant forgoing funding and ceding control to the federal government. Perhaps this was a risk they were willing to take, given that they did not truly oppose the idea of an exchange.

Our account demonstrates that the states that have engaged with the ACA most consistently appear to have experienced greater exchange-related success. But each aspect of states' engagement with or resistance to the ACA must be counted to fully paint this picture, with significant variation among states. This variation should give pause to those considering next steps in health reform, because state variation can mean innovation and improvement but also lack of coverage, disparities, and diminished access to care.

The 2020 presidential election approaches as we contemplate the ACA's signing anniversary. Throughout the primary debates, a core group of Democratic contenders have advocated for an incremental health reform approach that builds on the exchanges, not just by expanding the exchanges' tax subsidies but also by building the public option so quickly discarded in 2009. Some have advocated for dismantling the private provision of health insurance altogether. President Trump has said he will have a new health reform proposal in January 2021, with no further detail, but if 2017 is a guide, a new proposal is unlikely to include a dismantling of the exchanges. In fact, the Trump administration has tried to use the messiness of federalism and the fight over exchanges to both blame-shift and credit-claim, that is, taking credit for any positive developments—such as decreases in premiums—and blaming President Obama, congressional Democrats, and state leaders for any struggles.

Regardless of how new health reform proposals play out, a certain portion of health care decision making is nearly guaranteed to be punted to the states. (Even Senator Bernie Sanders's Medicare for All bill keeps the Medicaid program for long-term care coverage.) As we've learned from the ACA's exchanges, state-level cooperation and opposition are likely to play a major role in shaping the success or failure of future health reform.

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