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ACRONYMS

ACA	Patient Protection and Affordable Care Act
AHIP	America's Health Insurance Providers
ALEC	American Legislative Exchange Council
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
HIPAA	Health Insurance Portability and Accountability Act
HHS	Department of Health and Human Services
MLR	medical loss ratio
NAIC	National Association of Insurance Commissioners
NAMD	National Association of Medicaid Directors
NFIB	National Federation of Independent Business

PREFACE

The Patient Protection and Affordable Care Act (ACA) is by far the most crucial health care reform enacted in the United States since the adoption of Medicare and Medicaid in 1965. One of the most striking things about the ACA is the intense political battle that has surrounded this reform, both before and since President Barack Obama signed it into law in March 2010. In the United States, health care reform is very much an unfinished fight, and our book is devoted to the politics surrounding the implementation of the ACA in the four years following its enactment.

This project began shortly after Daniel Béland and Phil Rocco met for the first time, during the 2013 meeting of the American Political Science Association, and realized we were both captivated by the ongoing politics of health care reform and that some collaborative work on the topic should take place. Through a flurry of e-mails exchanged in the days following that Chicago meeting, Alex Waddan became involved in a conversation that would soon convince the three of us we should write a book on the topic. The project moved rapidly because we each had already conducted extensive research on the ACA.

From the beginning of our conversation, it became clear we wanted to focus on federalism and the politics of implementing the ACA in the fifty states. Although politics at the national level and legal challenges to the constitutionality of the ACA are fascinating and crucial in shaping the implementation of the ACA, we wanted to study the politics of health care reform in the states to account for diverging patterns of consent and dissent in implementing the ACA. As we began working on this book, we decided to focus on three major policy streams central to the effective application of the ACA: the creation of health insurance exchanges offering affordable insurance packages with government subsidies to low-income Americans not eligible for Medicaid, the expansion of Medicaid to cover those with incomes up to 138 percent of the federal poverty level, and regulatory reform designed to limit insurance premium increases and compel insurers to spend most of their revenues on medical care. In each of these areas state-level actors were required to act to make the law work effectively. As we show through this book, the law's extended and highly contentious implementation process caused those state actors to behave in ways that varied dramatically across the distinctive policy streams of the reform.

Conducting interviews and looking at the evidence available from both quantitative data and the set of case studies we examined, we noticed that these varia-

tions resulted from more than the states' political inclinations or idiosyncratic features of the state reform contexts. Each of these three streams operated according to a different political logic. Although we recognized that what happens in one of the ACA reform streams could affect the situation in another stream, it proved clear to us that patterns of consent and cooperation characterized regulatory reform, a situation that contrasted with Medicaid reform and, especially, health insurance exchanges, which witnessed much more dissent and much less cooperation. Especially striking to us was the fact that these political differences across reform streams are sometimes present even within the same state. By emphasizing the diversity of the politics of the ACA in the states, our book contributes to knowledge about how and why such consequential health care reform is unevenly implemented across the fifty states.

We chose to limit our study to the first four years of the ACA's implementation. Although we knew debates about the ACA would be ongoing, and interpretations of its history would continue to evolve as new evidence came to light, we believed that, in light of prior scholarship, four years set an important first benchmark for how the federal system responded to major reforms. Moreover, although the ACA's politics and policy may change in the future, its uneven implementation thus far has had direct and sometimes dramatic consequences on the ground for the well-being and economic security of millions of Americans. Although our book focuses on federalism and state politics, we understand that the key political decisions under investigation made in the fifty state capitals can have a profound and deeply felt impact on large segments of the population, which is why this politics matters so much and deserves close, comparative examination. We hope our book can help the reader better grasp why state officials made the decisions they did and why the implementation of the ACA is taking the sinuous path it is across the fifty states, in what remains a geographically fragmented health care system. As we suggest, studying state politics in a comparative perspective is a most insightful way to grasp the evolution of this system.

A number of great people directly assisted us in preparing this book. First, we thank Rachel Hatcher, Dylan Clark, Bo Kovitz, and Ishmael Wireko for their editorial and research assistance. Second, we are grateful to Weiping Zeng and the Spatial Initiative at the University of Saskatchewan for helping us prepare the maps featured in this book. Third, we thank the people who agreed to be interviewed as part of this project for their insight. Fourth, the reviewers provided most helpful feedback on our manuscript, which was significantly improved as a consequence. Thank you to them for taking the time to read our manuscript so carefully, and for offering both detailed and constructive comments. Fifth, at the University Press of Kansas, Fred Woodward and Chuck Myers provided admirable guidance and support, from the initial stage of this project to the publication process. We warmly

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Introduction

The battle over health care reform in the United States did not, as its supporters hoped, end with the adoption of the Patient Protection and Affordable Care Act (ACA) in March 2010. The very day President Barack Obama signed the ACA into law, a number of states made it clear they would challenge the law in court. As the *Washington Post* reported, "Not five minutes after President Obama signed health-care legislation into law . . . , top staff members for Virginia Attorney General Ken Cuccinelli II made their way out of his office, court papers in hand and TV cameras in pursuit, and headed to Richmond's federal courthouse to sue to stop the measure."[1] As the initial flurry of state lawsuits against the ACA suggested, health care reform opponents decided to strike back hard and fast, using powerful language to express their hostility toward the federal health care reform. Speaking at a conference held by the American Enterprise Institute in December 2010, conservative legal scholar Michael Greve issued a challenge to his colleagues in these blunt terms:

> This bastard [the ACA] has to be killed as a matter of political hygiene. I do not care how this is done, whether it's dismembered, whether we drive a stake through its heart, whether we tar and feather it and drive it out of town, whether we strangle it. I don't care who does it, whether it's some court some place [*sic*], or the United States Congress. Any which way, any dollar spent on that goal is worth spending, any brief filed toward that end is worth filing, any speech or panel contribution toward that end is of service to the United States.[2]

Greve's speech was only the beginning of a much larger attack on health care reform that, even four years after the ACA became the law of the land, has persisted. This is why, on April 1, 2014, just after the law's first open-enrollment period, President Obama felt the need to publicly defend the ACA, as he had on numerous occasions since he signed the legislation. At the core of this 2014 speech was his claim that the "Affordable Care Act is here to stay" and his statement that "those who have based their entire political agenda on repealing" the ACA should explain to people who already benefit from it why they want to repeal it. Importantly, he also claimed Americans "can stop refighting old political battles that keep us gridlocked," a statement that points to lasting political dissent over the ACA, both at the national and at the state levels.[3]

An enduringly controversial law, the ACA aims to gradually reduce the number of people in the United States who are uninsured, which stood at around 50

million in 2010, and to control spiraling costs associated with providing health care here. To do so, the government regulates the private insurance sector by scrutinizing prices and mandating broader access to coverage, creating health insurance exchanges to help individuals and small businesses purchase insurance, and making provisions for a large expansion of Medicaid, the state-run health insurance program for the poor. Yet the ACA's passage alone did not guarantee the achievement of these goals. The most important health care reform since the adoption of Medicaid and Medicare in 1965, the ACA is a complex and multifaceted piece of legislation, with rollout set to take place gradually over nearly a decade, through 2019. Because of this extended time frame, the complexity of the legislation, the central role of states in its implementation, and the enduring political opposition discussed above, the enactment of the ACA was not the end but rather the beginning of a new chapter in the fight over health care reform.

In this context, opponents such as the National Federation of Independent Business (NFIB), insurance companies, Tea Party supporters, and conservative activists quickly mobilized across the institutional terrain of the US government—in the courts, at notice-and-comment sessions in federal agencies, in state capitals, and in the public sphere—to contest the reform before it could take root. Each of these constituencies had different reasons to oppose the ACA. For instance, the NFIB took issue with requirements for employers, insurance companies disliked key aspects of regulatory reform, and Tea Party and conservative activists rejected the entire package. Despite their differences of opinion, opponents were not deterred by the enactment of the ACA. Instead, they organized across the country to stall or, at least complicate and undermine, its implementation.[4] The importance of this postenactment opposition became especially clear in fall 2013, when the obstacles put in place contributed in part to a problematic rollout of key aspects of the law, such as the proposed Medicaid expansion and the creation of health insurance exchanges. Here it is crucial to understand that opponents have mobilized politically in different ways with different levels of success, depending on the issue at hand. For instance, by April 2014, although half of the states agreed to expand Medicaid, barely a third of them decided to set up their own health insurance exchanges.

In this book, we argue that opponents of the ACA have used the US federal system to continue the fight over health care reform in ways that vary across the major components of the law. The ACA's institutional structure enables this contestation. To ensure that the bill would be perceived as a moderate reform, seemingly radical alternatives favored by the left of the Democratic Party, such as a single-payer system, were never seriously contemplated. Even more expansive versions of provisions on the table, such as a single, federally run health insurance exchange, were excised from the final form of the legislation.[5] As Eric Patashnik and Julian Zelizer have noted, the ACA did not restructure political institutions or health

insurance markets in a way that would have destroyed opposition to health care reform.[6] Thus, the law did not centralize health care arrangements in the manner championed by the many liberal advocates of reform. It did not establish anything resembling "Medicare for all," which would have left the federal government as the dominant player in the organization of health care. In fact, rather than simplifying the already extraordinarily complex system, the ACA depended on integrating more layers into the existing policy fabric. Most importantly, the ACA dispersed governing authority to a patchwork of state governors, legislatures, and regulatory agencies with which the Department of Health and Human Services (HHS) had to collaborate.[7] As our book shows, these state-level policy makers were often simply unwilling to cooperate in the law's application. Hence the ACA's complex design and delegation of implementation created a window of opportunity for its opponents at the state level to shape, and in some cases obstruct, implementation. In 2010, parties and groups opposed to the ACA poured their energies into state electoral contests, contributing to significant Republican gains and leaving a state implementation context divided along partisan lines.

Importantly, however, elected officials at the state level did not have equal opportunities to obstruct *all* of the relevant provisions of the ACA. The ACA is not a coherent reform; rather, it is a bundle of policy changes with their own political logic and institutional structures. Most importantly, each stream of reform within the ACA—health insurance exchanges, Medicaid expansion, and regulatory reform—interacts with the federal system in a different way because each is associated with unique policy legacies, institutional settings, and public sentiments.[8] These variations, we argue, made some reform streams more vulnerable to state-level contestation than others did. Our book compares and contrasts how state elected officials behaved within three of these reform streams, all of which are major components of the ACA that depend crucially on the involvement of state governments. In particular, we focus on the development of health insurance exchanges (also known as health insurance marketplaces), the expansion of Medicaid, and the introduction of new health insurance regulations.

Through a detailed analysis of the policy legacies, institutional settings, and public sentiments that characterize each of these reform streams, we explain why the state-level politics of ACA implementation has varied across the exchanges, Medicaid, and regulatory reforms. After formulating a coherent analytical framework to study the politics of implementation in an intergovernmental context, we compare and contrast state-level debates and actions in relation to these three streams from the signing of the ACA in late March 2010 to the end of the first open-enrollment period in late March 2014.

Our comparative analysis reveals important divergences in the politics of the three reform streams under consideration. The implementation of reform in each

of the different streams under consideration did not take place in a sealed-off policy silo, completely detached from developments elsewhere. The wider political fight over the ACA's legitimacy clearly affected the decision making of state policy makers and other stakeholders across all the streams, be they emboldened in their resistance to the law or encouraged to collaborate with the federal authorities. Yet, as we show, actors were constrained or enabled by the implementation dynamics in each stream. Different institutional configurations and varied incentives framed how those involved viewed the costs and benefits of cooperation or opposition to building exchanges, expanding Medicaid, or enforcing regulatory reform. Out of these streams, the politics of health insurance exchanges has triggered the most dissent and intergovernmental conflict. In sharp contrast, the implementation of regulatory policy has typically taken the form of bargaining among policy elites over the details of reform, resulting in the emergence of wide consent among states to implement weaker reforms. Furthermore, we suggest that Medicaid expansion is a more controversial issue than regulatory reform for the states. Yet this reform stream brings a greater level of state participation than do health insurance exchanges, which have the strongest level of conflict over implementation, largely because of a robust legacy of state-federal collaboration on Medicaid. Nevertheless, the refusal of states to participate in Medicaid expansion has much more direct consequences on citizens than the refusal of states to set up their own health insurance exchanges, where the federal government can simply act on its own. This option is not available in the Medicaid reform stream, in which state action is required to implement expansion for potentially newly eligible individuals. Thus, in terms of a clear contrast between recurrent dissent (Medicaid, exchanges) and negotiated consent (regulatory reform), the politics of ACA implementation varies greatly from one reform stream to another, a situation our comparative analysis both describes and explains.

Beyond widening our understanding of the politics of ACA implementation, our book draws broader lessons for the analysis of federalism and intergovernmental politics in the United States. First, our analysis points to the fact that the federal system is not one unified, homogenous constitutional battlefield but rather many distinct policy battlefields, each characterized by its own political logic. Factors such as policy legacies, institutional configurations, and public sentiments all shape politics in the federal system. Second, the very nature of this political logic tends to direct the tactics of state actors during policy implementation. Third, these tactics are not homogeneous but diverse in nature because they involve consent, dissent, or a combination of both. Finally, in the politics of intergovernmental policy implementation, different kinds of contestation feature different actors, audiences, and probabilities of victory for opponents of the reform at stake.

THE ENDURING CHALLENGE OF HEALTH CARE REFORM

Grasping the politics of ACA implementation requires an understanding of the multifaceted problems the US health care system faced before the reform was even conceived. In reality, the problems President Obama and his allies set out to remedy had long been in the making. When Governor Bill Clinton was campaigning for the presidency in 1992, he denounced a system that left "60 million Americans without adequate health insurance and bankrupts our families, our businesses, and our federal budget."[9] In 1993, 39.7 million Americans, amounting to 15.3 percent of the population, were uninsured;[10] yet the United States, in devoting 13 percent of its gross domestic product (GDP) to health care, spent more on health care than any other industrialized nation.[11] Clinton's failure to correct these issues led some commentators to conclude that the institutional fragmentation of the US government prevented the enactment of a comprehensive reform package in Washington, DC.[12] Yet, fifteen years later, during the 2008 campaign and at the beginning of the Obama presidency, the problems of access and cost had worsened enough that Democrats felt that health care reform had once again become too pressing an issue to ignore.

After the legislative debacle of the Health Security Act, the Clinton administration managed to push through some incremental health reforms that helped improve access to care for a few groups. The Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996, made it easier for workers, particularly those with preexisting medical conditions, to keep their insurance if they changed jobs.[13] Additionally, the State Children's Health Insurance Program (SCHIP, now known as CHIP) expanded access to health care for children living in households with incomes up to 200 percent of the federal poverty level but whose parent or guardian could not afford to purchase private insurance.[14] This program, which allocated $24 billion over five years through block grants to the states, represented the "nation's largest publicly funded health insurance expansion" since the creation of Medicare and Medicaid in the mid-1960s.[15] Despite the uneven implementation of SCHIP, by 2006 an estimated 6.7 million children were benefiting from the program.[16] Yet, the number of uninsured Americans remained constant. In the wake of the passage of HIPAA, President Clinton claimed that the law represented a "long step toward the kind of health care our nation needs."[17] However, in reality, whatever the merits were of the measures passed in the 1990s, 14.9 percent of Americans were still uninsured in 2008.[18] In addition, many millions more were underinsured and faced the possibility of huge, potentially unaffordable costs if they needed health care.[19]

In addition to no significant reduction in the proportion of Americans lacking insurance in the years since President Clinton's reform initiative, the intervening

years had brought a continuing escalation of health care costs. By 2008, health care costs had risen to 16 percent of the GDP, reinforcing the country's status as the biggest health care spender in the world. In terms of universal coverage, France spent 11.2 percent, Germany 10.5 percent, and the United Kingdom 8.7 percent of their respective GDPs on health care.[20] In January 2010, as the ACA was still in the legislative process, the Congressional Budget Office (CBO) warned, "The biggest single threat to budgetary stability is the growth of federal spending on health care—pushed up both by increases in the number of beneficiaries of Medicare and Medicaid (because of the aging of the population) and by growth in spending per beneficiary that outstrips growth in per capita GDP."[21] Furthermore, state governments were becoming increasingly concerned over how to sustain their contribution to Medicaid, with state officials forced into uncomfortable choices between spending on health care coverage for low-income constituents and other crucial expenditures.[22] In addition, although they typically passed on some of the increase in health care costs to consumers and workers, employers who offered insurance to their employees became increasingly worried about the rise in such costs.[23] For example, by the mid-2000s, Starbucks was spending more money on health insurance for its employees than it was spending on coffee beans.[24] These pressures meant that the long-term viability of the employer-based model of insurance had to be questioned.[25] In 2000, 65.1 percent of Americans enjoyed employment-based insurance, but this number had diminished to 56.1 percent in 2009.[26]

These aggregate numbers about the uninsured and costs of care were widely cited in the public domain, fueling pressure on the federal government to take action.[27] Importantly, however, the number of uninsured Americans did not represent a balanced cross section of society. Unsurprisingly, the disparities within the US economy are reflected in the demographic composition of the uninsured; focusing only on the overall number of people uninsured tends to overlook significant discrepancies in access to health insurance by their race and ethnicity. For example, in a 2002 report commissioned by Congress, the Institute of Medicine commented:

> There are wide differences between racial and ethnic groups in access to health care and the availability of health insurance. Minorities, especially Hispanic and African-American families, are less likely than whites to have private health insurance. Or if they have insurance, minorities are more likely than whites to be enrolled in health plans that place tight limits on the types of services that patients may receive. Also, the best quality health care services and providers are not always found in minority communities.[28]

Six years later, when President Obama was elected in 2008, these inequities remained acute. The rate of uninsured among white, non-Hispanic Americans

was 10.8 percent. Of African Americans, 19.1 percent were uninsured, whereas for people of Hispanic origin that number was higher still, at an astonishing 30.7 percent.[29] A key aspect of these discrepancies was that African Americans and Hispanics were significantly less likely to have access to employer-related insurance. In 2008, 65 percent of white Americans had some kind of employer-related insurance, but for African Americans and Hispanics the numbers were 48.8 percent and 41 percent, respectively.[30]

These numbers matter in part because of their social significance but also because of their potential impact on how political actors might construe the likely "winners" of health care reform.[31] For all the worries about the uninsured, most Americans did have insurance, and in designing any reform it was important for reformers not to appear to be threatening existing insurance coverage. One cross-national survey of people's opinions of health care arrangements in their own countries is especially revealing about contradictory tensions policy makers in the United States faced when crafting a reform package. US respondents to the survey were the most likely to say their country's health care system needed major surgery, but they were also the most likely to express confidence in the quality of treatment available: "Compared with the other 10 countries, the U.S. had the highest percentage of respondents who reported being very confident they would receive effective treatment (34.7%) and also the highest percentage saying they were not at all confident they would (9.2%)."[32]

This combination of factors made the task of devising comprehensive change highly problematic. This was the case because reformers needed to prove they could simultaneously control health care costs and expand access to health insurance for millions of Americans without appearing to threaten the arrangements of those already satisfied with their insurance. Furthermore, within the political arena, as President Clinton had discovered, coming up with a blueprint for reform was the easy part when compared with the task of getting Congress to make a serious effort at legislating it.

When the time came to design health care reform at the outset of Obama's presidency, however, significant variation existed in the policy legacies of insurance exchanges, Medicaid, and regulatory reform. These policy legacies had an impact on the content of the final legislation adopted in March 2010. First, concerning health insurance exchanges, ideas such as individual mandates and purchasing pools had long been popular within policy circles, including conservative ones. Some of these ideas influenced the 2006 Massachusetts health insurance reform, sometimes known as "Romneycare," a platform viewed as bipartisan because both Democratic state legislators and Republican governor Mitt Romney ended up supporting it.[33] Nevertheless, virtually no states had followed the lead of Massachusetts in making these ideas into concrete policy reforms. Second, since the 1980s,

Medicaid had expanded significantly as a program, and, in the year preceding the enactment of the ACA, a number of reform advocates had pushed for expanding it further to reduce the number of uninsured among low-income Americans.[34] Finally, when it came to regulatory reform, both the states and the federal government had already begun experimenting with rate regulation and the medical loss ratio (MLR), which involves submitting "data on the proportion of premium revenues spent on clinical services and quality improvement."[35] Thus, the three reform components on which we focus—health insurance exchanges, Medicaid expansion, and regulatory reform—already enjoyed some level of elite support before the enactment process for the ACA even began. Nevertheless, as the reform effort took shape in 2009, strengthened GOP opposition would undermine this consensus and lead to a much more contentious process of enactment and implementation.

During the prolonged and highly divisive political process that led to the enactment of the ACA, what was at stake became increasingly clear as both controlling costs and extending coverage in a world of complex policy legacies, powerful vested interests, and GOP opposition proved a difficult task. If anything, President Obama's choice to allow Congress to prepare a detailed policy blueprint instead of providing one himself, as President Clinton had done fifteen years earlier, slowed down an already slow-moving enactment process. This situation explains why the surprise election of Republican Scott Brown to the Senate in January 2010 was so disruptive, because Democrats lost their supermajority of sixty seats before the final compromise between the House and the Senate bills. In the end, in the absence of Republican support for the legislation, this turn of events forced Democrats to adopt the Senate version of the legislation, which featured a more decentralized approach to health care reform than the House version. In particular, in terms of the health insurance exchanges, Congress did not adopt the purely national approach featured in the House bill but rather a system in which states could set up their own exchanges. This choice paved the way for significant policy disparities and inadvertently created a political window of opportunity for opponents of the ACA within the states to use their power over the creation of state-operated exchanges to express their discontent toward the federal legislation as a whole.

HOW POLICY LEGACIES, INSTITUTIONAL FRAGMENTATION, AND PUBLIC SENTIMENTS SHAPE POSTREFORM POLITICS

Because of the ACA's decentralized design, state-level electoral victories by Republicans in 2010 provided the leverage opponents needed to refight the battle over health care reform. Yet in contrast to existing scholarship on the politics of ACA implementation, we show evidence of wide variation in opponents' opportunities

to challenge individual elements of health care reform. Although we agree with existing scholarship that partisanship and political polarization are driving forces of state governments' reaction to the ACA, our comparative analysis of intergovernmental politics reveals major differences in how opponents of the ACA responded to exchanges, Medicaid, and regulatory reforms. We argue that these variations are the result of three important factors: *policy legacies, the level of institutional fragmentation,* and *public sentiments.*

First, *policy legacies* consist of preexisting institutions and intergovernmental relationships that predate the passage of the ACA. Strong policy legacies act as a buttress against state-level opposition by raising the bar opponents must clear to stall reform. For instance, if a federal policy builds on popular reforms already undertaken at the state level, it may be difficult for opponents to build a coalition to reverse a "tide" of reform many years in the making. By contrast, weak policy legacies allow opponents of reform to leverage uncertainty about policy outcomes to sew doubt about embracing a new reform.

Policy legacies vary greatly across our three reform streams. For instance, whereas Medicaid is a well-established program associated with a long history of federal-state interactions, health insurance exchanges are a new policy instrument. The policy terrain of health insurance exchanges is both recent and undeveloped. Prior to the ACA, only Massachusetts had a working health insurance exchange. As for the policy legacies relevant to regulatory reform, states had more variable policy frameworks than in the Medicaid program in existence in most states since the late 1960s. Nevertheless, unlike in the case of the exchanges, most states had basic regulatory frameworks that aided in implementation.

A second focus in our analysis is *institutional fragmentation,* the extent to which a policy divides decision-making authority among multiple actors. Institutional fragmentation also varies considerably across our three cases. On the one hand, the most fragmented of these reform streams is health insurance exchanges. Health insurance exchanges, unlike Medicaid reform, featured weak fiscal incentives for states to participate and, unlike the lower profile of regulatory reform, necessitated highly visible state legislation to establish exchanges. On the other hand, regulatory reform is the most integrated and the least fragmented reform stream under consideration, in part because federal bodies have a stronger coercive capacity and because preexisting regulatory frameworks allowed state insurance departments to implement the reforms without additional action by state legislatures. We argue that institutional fragmentation empowers opponents of reform by allowing them to use institutional veto points to their advantage. If states must go to greater lengths to participate in federal reforms, and especially if they lack adequate incentives to do so, opponents may be able to fight back without much energy at all.

Finally, there are clear variations in *public sentiments*—defined as the public salience of, and support for, a policy—across our three reform streams. For instance, regulatory reform has a very low public profile, whereas both Medicaid and health insurance exchanges are widely debated in the media and the political arena, thus making them highly visible to a divided public. As we show, high salience and mixed public support exacerbate political conflict over Medicaid and health insurance exchanges. By contrast, low salience in the regulatory reform stream fosters a politics of negotiated consent dominated by behind-the-scenes agreements between state and federal officials.

These three types of contextual differences shape the political opportunities for dissent and consent in the politics of ACA implementation across the three reform streams we investigate. First, health insurance exchanges have faced high-profile but mixed public sentiments as well as the lowest level of consent and cooperation because of limited policy legacies in the states combined with institutionally fragmented reform that gives states the option to refuse to establish exchanges. In addition, many states simply refuse to create their own exchanges as a way of expressing their opposition to the ACA. At the outset, opponents of the ACA in many states saw few downsides to this strategy. Although refusing to create exchanges would allow them to keep the debate about the ACA alive, they would suffer little blame for noncooperation, especially because the federal government would become responsible for establishing exchanges and providing premium tax credits to consumers in these states.[36] In fact, the failure of states to cooperate became the basis for a lengthy fight in federal courts in *King v. Burwell* (2015).

Second, Medicaid remains an intermediary case with its high public profile, making it more likely than regulatory reform to trigger heated political debates. However, Medicaid's well-established policy legacies and greater federal fiscal incentives tend to somewhat mitigate conflict and generate a greater level of state consent, at least if measured in terms of the number of states that expanded their Medicaid programs compared with the number of states that established their own exchanges. Finally, in regulatory reform we observe negotiated consent rather than the politics of dissent. Opponents of these reforms found it more challenging to engage in dissent because of deeper state policy legacies and an integrated institutional design combined with a low public profile that allows civil servants and other actors to bargain behind closed doors.

The divergent patterns of politics in the three streams we examine have significant policy consequences. For instance, although the existence of a federal "fallback" insurance exchange allowed citizens to purchase coverage regardless of states' cooperation, state dissent kept political conflict over the ACA alive and enabled challenges to the ACA in federal courts, and ultimately the Supreme Court, regarding the applicability of premium-assistance tax credits in states that did not

develop their own exchanges. Without these tax credits, enrollments in health care plans were projected to decline from 9.6 to 4.1 million, a decrease of 70 percent, and average premiums were projected to rise by 47 percent.[37] In June 2015, however, in a much-anticipated decision, the Supreme Court ruled that the law "authorized federal tax credits for eligible Americans living not only in states with their own exchanges but also in the 34 states with federal marketplaces."[38] However, state dissents on Medicaid pushed nearly 4 million poor, uninsured adults into a "coverage gap" because their income was too high to qualify them for current Medicaid benefits but below the lower limit for premium tax credits in the insurance marketplace.[39] Furthermore, states refusing to expand their Medicaid programs included Florida, where 1,253,000 people would potentially have become eligible for the program under the terms of the ACA; Texas with 1,186,000; and Georgia with 682,000. In contrast, in California, the decision to expand meant that more than 2.1 million people became newly eligible to register for Medicaid coverage.[40] Conversely, although states obviously varied in their approaches to enforcing the ACA's regulatory reforms, all but five states comply with the law, which means citizens can hold the vast majority of state governments accountable for consumer protection.[41]

In order to support our comparative claims, our methodological approach features a detailed analysis of policy legacies, institutional settings, and public sentiments across our three reform streams. Each of the three factors under consideration requires us to examine different sources of data, from court rulings, legislative texts, and media sources to interviews with policy makers and health care experts to public opinion data and academic studies. Gathering data on individual reform streams is not the end in itself because our goal is purely to grasp the political logic of ACA implementation in states as it varies *among* our three reform streams. Although our conclusions rely predominantly on qualitative case comparisons between reform streams, we also leverage descriptive quantitative data analysis for each individual stream to reveal broad patterns in the politics of implementation across all fifty states.

OVERVIEW

This book comprises five main chapters. The first chapter reviews and draws on the literature of federalism and intergovernmental relations to formulate the book's analytical framework, centered on the role of policy legacies, institutional settings, and public sentiments. The second chapter sets the scene for the politics of ACA implementation, describing how the institutional design of the reform created opportunities for its opponents to strike back at the state level and detailing how the 2010 elections made state elected officials potential veto players for the reform. Our

assessment of the ACA's political context is followed by three chapters that apply our analytical framework to the politics of health insurance exchanges, Medicaid, and regulatory reform, respectively. These chapters illustrate the complex ways in which policy legacies, institutional settings, and public sentiments interacted in each of the three reform streams, framing how state policy makers perceived the incentives, opportunities, and threats contained in the ACA and how they reacted to those perceptions. As we show, these factors could push and pull in different directions, producing a variety of results across the states. The chapters on exchanges and Medicaid include case studies of events in selected states that provide insight into the reasoning that guided policy makers and help explain the logic behind what might seem like some counterintuitive developments in terms of whether states established their own insurance exchanges or expanded their Medicaid programs. The chapter on regulatory reform features only brief case studies but concentrates on early-stage negotiations and investigates how stakeholders negotiated their resistance, compromise, or cooperation with the requirements of the ACA. The book finishes with a short conclusion that directly compares and contrasts our three reform streams to further assess our claims about consent and dissent in the intergovernmental politics of ACA implementation.