By Michael S. Sparer

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Federalism And The ACA: Lessons For The 2020 Health Policy Debate

Michael S. Sparer (mss16@columbia.edu) is a professor in and chair of the Department of Health Policy and Management, Mailman School of Public Health, Columbia University, in New York City.

ABSTRACT Establishing a balance of power between states and the federal government has defined the American Republic since its inception. This conflict has played out in sharp relief with the implementation of the Affordable Care Act. This article describes the interplay between state and federal governments in the implementation of the act in three areas: the expansion of eligibility for Medicaid, implementation of the insurance Marketplaces, and regulation of insurers. The experience shows that states are intimately involved in health care and that useful policy and fiscal advantages can result from that involvement. However, strong national standards are critical to preventing partisan politics from trumping the health policy process.

To accomplish its substantive goals—to reduce the number of uninsured people, control costs, and make the health care system more effective—the Affordable Care Act (ACA) added new rules and organizational structures to an already complicated and constantly evolving intergovernmental health care partnership. This article reviews how federalism (the sharing of power between different levels of government) influenced the implementation of the ACA, with a particular focus on efforts to aid the uninsured.

In some cases, the answer seems obvious: The law as written required each state to expand eligibility for its Medicaid program, but the Supreme Court struck down that mandate as unconstitutional, and more than a dozen states have refused to adopt the eligibility expansion. In this case, "partisan federalism"[1] has stymied the original legislative intent and undermined the goal of moving the country closer to universal coverage.

In other cases, however, the law's federalist structure had a different impact, offering a partial antidote to the partisanship that surrounds the ACA by providing Republican officials in some states with political cover to implement unpopular parts of the law and later offering Democratic officials a way to protect the law against concerted attacks by the administration of President Donald Trump. As a result, several Republican-dominated states adopted the Medicaid expansion in ways not originally envisioned by the law, several Democratic-dominated states enacted rules that counteract recent efforts to weaken the law's consumer protections, and states across the political spectrum have worked with federal officials to divide the tasks involved in running an insurance exchange, or Marketplace. This version of ACA federalism is consistent with a familiar pattern in American health care governance, in which state and federal officials prompt and prod each other to reach intergovernmental bargains—each relying on the other for political, economic, and administrative cover.

The complicated federalism of the ACA reflects an ongoing trend: As the federal government takes on an ever-greater role in organizing and regulating the American health care system, it generally does so in partnership with the states, and the partnership at different times advances or hinders the prospect of policy success. The

mixed outcomes generate calls by some for a more dominant federal role (perhaps by expanding Medicare to cover all Americans, as proposed by Sen. Bernie Sanders [I-VT]), while others push for a return of greater authority to the states (as proposed by the Trump administration). However, the odds are high that the intergovernmental dynamics that shaped the ACA will also shape the reform agenda going forward.

The Roots Of Health Care Federalism

The debate in the US over the best intergovernmental division of labor dates back to the eighteenth century. The nationalists, led by Alexander Hamilton, lobbied for a strong federal government fueled by a powerful executive branch. James Madison proposed a large but weak central government in which the states would be an important check on federal power. The so-called antifederalists, such as Thomas Jefferson, favored states' rights and a state-dominated federalism, and they warned that federal control over the economy was a backdoor path to monarchy. The constitution that emerged was a compromise document, and 250 years later the federalism argument remains at the core of American politics.

The politics of health care federalism were initially less contentious, since before the 1920s there wasn't much of a health care system for any level of government to operate or oversee. The federal government owned a few hospitals for soldiers and sailors but otherwise adopted the Jeffersonian view that health policy (and economic policy more generally) was outside of its constitutional jurisdiction. The states had no such constitutional constraints but did little other than operate hospitals for the developmentally disabled and mentally ill. Local governments were more engaged, with most developing a rudimentary public health infrastructure, along with some clinics and hospitals for the poor, but these initiatives were underfunded and small scale.

The health system changed dramatically beginning in the 1920s, however, and soon thereafter so did the roles of both the federal government and the states. The health system changes came first, starting with extraordinary growth of the private-sector hospital industry. That industry was soon unexpectedly at risk of bankruptcy as a result of the catastrophic economic depression in the early 1930s. It responded by creating Blue Cross, which encouraged groups of workers to prepay for the right to hospital care—a strategy that provided needed cash to struggling hospitals.[2] The for-profit commercial insurers soon followed, with indemnity health insurance plans that competed by experience rating.

Public-sector changes followed. President Franklin Roosevelt, a Democrat, argued successfully that the US needed an empowered federal government to respond adequately to the nation's economic problems. President Roosevelt engineered the New Deal, under which the federal government, often in partnership with the states, became the key driver of both economic and social welfare policy. Importantly, however, the physician community persuaded him not to seek national health insurance and to leave to the states the authority to regulate the insurance industry.

Medicare and Medicaid, enacted together in 1965, constituted the beginning of a public health insurance safety net, the former a centrally administered program with uniform national rules for seniors and the disabled, and the latter a series of state-administered programs for the poor. Meanwhile, the states continued to regulate the individual and small-group commercial insurance markets, while large employer-sponsored plans were largely unregulated because of the Employee Retirement Income Security Act (ERISA) of 1974, which exempts "self-insured" employer plans from state regulation.

As the system evolved into these disparate federalist models, there was an ongoing debate over the virtues of state authority (encouraging experimentation, adapting to local conditions, and encouraging democratic decision making) versus arguments for greater national authority (fiscal capacity, equity, and efficiency).[3] During the 1990s and early 2000s, however, it was Medicaid's evolving intergovernmental partnership that produced insurance expansions for millions of Americans—first through a series of federal mandates that required states to expand coverage for children, and later through a series of intergovernmental negotiations as states implemented program expansions financed primarily with federal dollars.[4]

The ACA, enacted in 2010, adopted several strategies to make health insurance more available and affordable, including expanded eligibility for Medicaid, new insurance Marketplaces, and increased oversight of the private insurance industry. Each of these initiatives combined new federal rules with significant opportunities for state flexibility and intergovernmental bargaining. Over the past decade, however, each initiative has followed an unexpected path, providing important lessons along the way.

Federalism And The ACA Medicaid Expansion

For much of Medicaid's early history (that is, from the mid-1960s to the late 1980s), states

had broad discretion to set Medicaid eligibility criteria, which led to significant variation in program coverage as conservative opposition often trumped the lure of a generous federal funding match. Indeed, one state (Arizona) did not even join the program until 1982, signing on only after receiving federal permission to run its entire program through a managed care delivery system.

In an effort to reduce the interstate variation (and the number of uninsured people), in the late 1980s Democrats used the congressional budget reconciliation process (which prohibited a filibuster) to impose federal mandates that required states to expand coverage (primarily for children). This effort dramatically increased enrollment. The Medicaid mandates generated significant intergovernmental tension, and in the early 1990s the Democratic administration of President Bill Clinton addressed state concerns by streamlining the process by which states could negotiate waivers from general program rules. This enabled states to deliver Medicaid services in ways consistent with state-based preferences, such as state-designed managed care initiatives. These waiver negotiations led to a culture of "executive federalism" in which intergovernmental bargaining became the Medicaid norm rather than the occasional exception.[5]

As part of its effort to aid the uninsured, the ACA returned to the 1980s-style Medicaid mandate model, requiring states to expand coverage to all otherwise eligible people with incomes at or below 138 percent of the federal poverty level. At the same time, in response to state-based lobbying, Congress also sweetened the fiscal benefit to the states by requiring the federal treasury to pick up 100 percent of the expansion cost between the 2014 start date and 2016, and then phasing the share down to 90 percent by 2020. Despite the lure of additional federal dollars, twenty-six Republican-led states joined a lawsuit challenging the constitutionality of the entire ACA, including the Medicaid mandate. While the US Supreme Court upheld most of the ACA in *National Federation of Independent Business v. Sebelius*, it struck down the Medicaid mandate, converting it to a state option.[6] The Court found unconstitutionally coercive the provision in the law that authorized federal officials to withhold all federal funding from the "traditional" (pre-ACA) Medicaid program if states did not participate in the "new" ACA Medicaid expansion.

Following *NFIB v. Sebelius*, states had to deal with conflicting pressures when deciding whether to adopt the Medicaid expansion. The fiscal case for expansion was straightforward, given the generous federal funding offered.[7] There also was strong interest-group support from hospital systems and other providers, consumer advocates, and various business organizations. At the same time, there was powerful opposition, led by Republican politicians, conservative think tanks, and grassroots Tea Party activists. The opposition ranged from the practical (finding funds to pay the eventual state share) to the clearly political (opposing any collaboration with "Obamacare").

The political dynamics around Medicaid expansion varied enormously and cannot be easily summarized. Nonetheless, four themes stand out. First, all states with Democratic leadership in both the executive and legislative branches implemented the expansion. Second, most (but not all) states with Republican leadership in both the executive and legislative branches encountered fierce partisan opposition to adopting the expansion, and fourteen of those states had not expanded as of mid-January 2020. Third, many states with Republican leadership or divided government have worked with federal officials to fashion an intergovernmental bargain that has facilitated expansion adoption. Finally, largely because of these intergovernmental bargains, the number of expansion states continues to grow, from twenty-five (including the District of Columbia) in 2014 to thirty-seven as of January 2020.[8]

The intergovernmental bargaining is illustrated by the Medicaid expansions in Arkansas and Indiana. In Arkansas state and federal officials agreed to implement a waiver under which the state uses the additional federal Medicaid dollars to purchase private coverage on its insurance Marketplace for expansion enrollees, which thereby permitted both the Democratic governor and the Republican legislators to claim credit for a novel approach.[9] Similarly, Indiana received permission to implement a consumer-choice model under which expansion enrollees receive comprehensive benefits only if they contribute to a personal account designed to work like a health savings account.[10]

The number of participating states continues to grow incrementally, even during the more ACA-hostile Trump administration. Over the past three years, five states have adopted the expansion, four of which have in place or are currently negotiating an intergovernmental bargain with federal officials.[8] The most controversial element of such bargains is the proposed beneficiary work requirement. Republicans suggest that such a requirement encourages healthy beneficiaries to work. Democrats cite evidence that the requirement imposes administrative burdens that unlawfully cause otherwise eligible people to lose coverage.[11]

The work requirement debate was key in Vir-

ginia, which adopted the Medicaid expansion in May 2018—only after the new Democratic governor, Ralph Northam, had persuaded enough Republican lawmakers to go along by promising to add work requirements. However, following a Democratic takeover of the state legislature, Governor Northam "paused" the waiver request.[12] Similarly, voter referendums that mandated expanding Medicaid in three Republican-led states (Idaho, Nebraska, and Utah) have prompted officials in those states to bargain for work requirements to accompany soon-to-be-implemented expansions. But federal court decisions that struck down work requirement waiver requests in Kentucky[13] and Arkansas[14] suggest that courts are likely to prevent their actual implementation.

The combination of electoral changes, voter pressure, interest-group advocacy, and the lure of significant federal funding is likely to lead even more states to look for an intergovernmental bargain that will provide political cover for a Medicaid expansion. This bargaining cannot always overcome partisan opposition or court nullification. However, the trend has been in that direction, although movement is slow.

Federalism And The ACA Marketplaces

The ACA sought to make private insurance more affordable and accessible for the self-employed and the small-business community by creating exchanges, known as Marketplaces, in which individuals and small businesses could choose between competing insurers. While the law directed each state to establish a Marketplace, it also provided that if a particular state failed to do so, the federal government would establish and operate a Marketplace on the state's behalf. The initial expectation, however, was that most states would enact their own Marketplaces. Indeed, in 2010 every state but Alaska took a Marketplace planning grant.[15]

A decade later only thirteen states (including the District of Columbia) fully operate their own Marketplace. Perhaps even more surprising, the binary choice set forth in the ACA (the state either creates a Marketplace or defaults to the federally facilitated Marketplace) has evolved into a complicated mix of hybrid models. In 2011, for example, federal officials created a so-called state partnership model under which six states retain functions such as outreach and education, while actual enrollment is done through the federal Marketplace. There also are six federally supported Marketplaces, in which the state operates the Marketplace but "rents" the federal enrollment platform. And even among the twenty-six states that defaulted to the federally facilitated Marketplace, seven have negotiated separate deals that allow them to maintain plan management functions. Moreover, constant adjustments are needed to calculate who does what, as several states have shifted from one model to another.[16]

The political dynamics around Medicaid expansion varied enormously and cannot be easily summarized.

For most states the initial decision about whether to create a state-based Marketplace reflected political support for (or opposition to) the ACA. Nearly all of the thirteen state-based initiatives were created by states with unified Democratic leadership, while nearly all of the nineteen states that completely defaulted to the federal Marketplace had unified Republican leadership.[17] But the issue was more complicated for the remaining states, nearly all of which hoped to maintain some policy and administrative control over their Marketplaces. Some states (such as West Virginia[18] and Oregon[19]) were reluctant to devote the needed resources; others were unwilling to be seen as collaborating with a law they were challenging in court.[20] Meanwhile, federal officials had their own incentive to negotiate an acceptable deal with the states—partly to demonstrate that the law was being implemented as intended, but also because Congress had not appropriated funding for what was turning out to be a large federal Marketplace.[20]

The complicated politics and intergovernmental bargaining during the Democratic administration of President Barack Obama were illustrated in Kansas. In early 2011 the state's Republican governor, Sam Brownback, announced his support for a state-based Marketplace, notwithstanding the state's participation in the litigation that challenged the legality of the ACA. Shortly thereafter, however, facing fierce pushback from the legislature and the state's conservative community, Governor Brownback reversed course and had the state return much of the Marketplace planning funding. But while Kansas thus defaulted to the federally facilitated Market-

place, its insurance commissioner, Sandy Praeger, negotiated a deal with federal officials according to which the state manages and regulates Marketplace activities, approves participating plans, reviews proposed rates, and provides consumer assistance. The agreement provides Kansas officials with political cover while also enabling them to exercise policy control.[15]

The political context of the intergovernmental bargaining changed dramatically after the 2016 election, as the Trump administration argued that the Marketplaces (and the ACA more generally) had failed and should be eliminated. While the repeal effort failed and the law survived, federal policy makers destabilized the Marketplaces by cutting funding for outreach, shortening the open enrollment period on the federal Marketplace, authorizing new types of insurance policies that did not comply with the ACA, and eliminating the tax penalty imposed on people without some form of insurance coverage.

In this new political environment, several liberal states that are operating state-based Marketplaces are compensating for some of the federal cutbacks by providing additional funding for outreach, extending enrollment periods, placing prohibitions on new types of noncompliant insurance policies, and even (in three states) implementing state-based individual mandates. As a result, while Marketplace enrollment for 2019 declined by nearly 4 percent in states that relied on the federal Marketplace, enrollment increased in the state-based Marketplaces by roughly 1 percent.[21] In response, at least four states (Nevada, New Jersey, New Mexico, and Pennsylvania) have either implemented or announced plans to convert to a state-based Marketplace.[16]

Perhaps more unexpected, however, are efforts by several conservative states to work with federal officials to stabilize their Marketplaces. Consider, for example, the dozen states that have implemented or are about to implement "reinsurance" waiver programs, which are designed to stabilize Marketplace premiums by subsidizing extremely expensive medical claims with a mix of state and federal dollars. There is no empirical connection between a state's Marketplace model and the decision to adopt this federally supported Marketplace stabilization program, as the participating states include those with fully state-based Marketplaces, hybrid models, and complete reliance on the federal Marketplace.[22]

Federalism And ACA Insurance Regulations

Before the ACA, the federal government exercised relatively little regulatory authority over the nation's private health insurance industry. Instead, state insurance departments ensured that carriers were fiscally solvent by adopting reserve and capitalization requirements, while also implementing rules designed to make coverage available, affordable, and relatively comprehensive. Not surprisingly, there was significant interstate variation in the regulatory requirements: While many states required insurers to cover certain services (ranging from mental health to dental care), a smaller subset focused on affordability—prohibiting exclusions based on preexisting conditions, requiring community rating, or creating state-based purchasing pools.

State oversight was generally limited to the individual and small-group insurance markets because of ERISA, which (as noted above) prohibits states from regulating companies that have self-insured health plans. More than 60 percent of the 173 million Americans with group coverage receive coverage through one of these self-insured plans. Interestingly, while the states could not regulate the self-insured firms, the federal government rarely did so, either, which left a regulatory vacuum for this component of the nation's insurance industry.

Despite the limited regulation of the self-insured market, the ACA's drafters were more concerned with problems in the individual and small-group markets and with the variation and perceived inadequacy of the states' regulatory efforts. For example, carriers in these markets were typically permitted to set premiums based on applicants' health status, thereby making it difficult for older and sicker people to obtain affordable coverage. Moreover, the various state-based benefit mandates notwithstanding, the covered services in these insurance markets were often bare-bones and inadequate. These issues were considered less prevalent in the large-group markets, where all employees generally paid the same premium and received the same coverage, regardless of health status.

Thus, there emerged in the ACA a two-pronged approach to a new federal regulatory regime: Certain rules were imposed on all private insurance products, including the self-insured, and another more comprehensive set of requirements were imposed just on products in the individual and small-group markets. For example, all private-sector insurance products are prohibited from imposing annual or lifetime limits on coverage. All also are required to cover preventive services without imposing copayments. But only products sold in the individual and small-group markets are required to include an essential health benefit package. And only those products must meet new federal rules that govern

how much of the premium must be spent on health care as opposed to insurers' administrative expenses.

Taken together, the ACA insurance regulations represented a dramatic change from the prior intergovernmental structure, imposing for the first time a host of federal regulations designed to make private insurance more affordable. However, instead of scaling back the states' regulatory role, the ACA—both as written and as implemented—significantly expands the states' administrative and oversight roles. First, the states are required to administer and enforce the federal requirements. Second, the states have discretion to impose requirements that exceed the new federal minimums.[23] Third, federal regulators decided in late 2011 to delegate to the states the task of selecting for their jurisdiction the scope and substance of the required essential health benefit package.[24]

Until recently, the ACA intergovernmental insurance regulation partnership had less partisan bickering than that found in the Medicaid expansion or Marketplace arenas.[9] This pattern has changed as a result of the Trump administration's efforts to scale back the scope and reach of the federal insurance regulations. For example, the ACA as written permitted insurers to offer short-term "transitional" plans that did not offer the essential health benefit package. The Trump administration extended the permissible duration of such plans from three to twelve months and also permitted such plans to be renewed for up to thirty-six months. In response, several states have banned the sale of such short-term plans, while others have imposed benefit or coverage requirements that go beyond the new federal minimums.[25] While this trend doesn't resemble the pattern of intergovernmental bargaining noted above, it is consistent with the more general pattern in which the ACA provides states with significant flexibility to adapt the law's national framework to their particular circumstances and politics.

Federalism And An American Version Of Universal Coverage

Health care reformers differ on how best to not only stabilize the ACA, but to also move beyond that law and provide affordable universal coverage for all. One strain of reform would eliminate or curtail private insurance by opening a dramatically expanded Medicare to the nonelderly. Moving from a mixed private-public approach to a fully federally run public program would reduce the inequities that are deeply rooted in the current fragmented and decentralized system. However, it would face daunting interest-

Health care reformers differ on how to move beyond the ACA and provide affordable universal coverage for all.

group, institutional, and cultural obstacles, including those posed by state governments. Any proposal that puts in place a centrally run universal program with no room for state administrative or policy discretion is an unlikely fit in the American polity, notwithstanding the popularity of the current Medicare program.

States are too prominent and too engaged in every aspect of the nation's health care system not to insist on playing an important ongoing role. Moreover, the intergovernmental partnerships of the sort originally built into the ACA (national standards combined with a significant state role) can have useful policy and fiscal advantages. By the same token, any future reform effort without such national standards (as with the Medicaid expansion after *NFIB v. Sebelius*) would be vulnerable to partisan politics that could trump federal fiscal incentives intended to achieve policy goals. Moreover, the risk is not simply that state policy makers would reject the proposed policy (that is, a Medicaid-type expansion), but that states' implementation of federal rules would be shaped by partisan politics.[26]

Based on past political history, viable future reform will need to fulfill certain criteria: guarantee the desired policy outcome (such as universal coverage), offer state governments some discretion over policy and administration, and ensure that state discretion does not turn into unacceptable inequities.[27]

The ACA offers three models for combining centralized and state-based approaches, each of which could achieve universal coverage without eliminating the private insurance system. First is the Medicaid expansion model as written—a federal mandate with state implementation. To be sure, this strategy would need to get around *NFIB v. Sebelius*, perhaps by imposing a milder penalty for noncompliance. Alternatively, Congress could create a new program that replaced Medicaid but kept its intergovernmen-

tal model. Second is the Marketplace model, a set of overarching federal rules implemented through a range of intergovernmental combinations. Third is the ACA insurance regulation model, a set of overarching federal rules administered by states with some discretion.

These models offer policy makers the conceptual raw material to develop the next generation of health reform, one that combines Medicare-type national rules with state administration and some defined state policy discretion. For those policy makers or policy analysts inclined to look internationally, Canada offers a useful model: Its national principles set conditions for shared funding, while also permitting provincial administration and some policy discretion. But one need not look abroad for a workable approach: The ACA itself suggests the sort of intergovernmental partnership that just might lead to a US version of affordable universal coverage. ■

NOTES

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