

2015

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Recommended Citation

Monahan, Christine M., "Safeguarding State Interests in Health Insurance Exchange Establishment" (2015). *Connecticut Insurance Law Journal*. 144.
<https://opencommons.uconn.edu/cilj/144>

SAFEGUARDING STATE INTERESTS IN HEALTH INSURANCE EXCHANGE ESTABLISHMENT

CHRISTINE H. MONAHAN*

This Article documents how, contrary to popular narratives, the states were given and took advantage of numerous opportunities to weigh in on health insurance exchange implementation under the Affordable Care Act. This engagement was driven by frequent informal consultation with federal officials, although states were also regular participants in regular notice-and-comment rulemaking. This Article identifies four factors that appear to have affected how much influence states were able to exercise over federal decision-making, and concludes by discussing how changing dynamics may encourage states to push for a more formal seat at the table in future exchange policy deliberations.

I. INTRODUCTION

News reporters and academic experts alike have heaped significant attention on the fact that the vast majority of states rejected the opportunity to run their own health insurance exchange under the Affordable Care Act (ACA), and instead opted for a federally operated exchange.¹ While states

* Yale Law School, J.D. expected 2016. I am indebted to the officials who shared their time and insights with me. I would also like to thank Professor Abbe Gluck for her supervision and guidance on this project, and my former colleagues at Georgetown's Center on Health Insurance Reform for inspiring my research into state implementation of the Affordable Care Act.

¹ See, e.g., Sarah Dash et al., *Health Policy Brief: Health Insurance Exchanges and State Decisions*, HEALTH AFFAIRS, July 18, 2013, available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=96; SARAH DASH ET AL., IMPLEMENTING THE AFFORDABLE CARE ACT: STATE DECISIONS ABOUT HEALTH INSURANCE EXCHANGE ESTABLISHMENT (Geo. Univ. Health Pol'y Inst. Ctr. on Health Ins. Reforms ed., Apr. 2013); Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST, Feb. 18, 2013, <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/18/its-official-the-feds-will-run-most-obamacare-exchanges/>; David Morgan, *Only 15 States Opt to Run Obamacare Exchanges*, CNBC (Dec. 13, 2012), <http://www.cnbc.com/id/100311739>; Alex Wayne, *Obama to Run Most Health Marketplaces as States Opt*

likely considered many factors as they came to this decision,² many ultimately were driven by partisan politics,³ and their vocal objections to these exchanges contributed to the popular conservative characterization of ACA implementation as a “federal takeover.”⁴ In light of state decisions to default to the federally run exchange, it is indisputable that the federal government has taken a larger role in the operation of exchanges than expected.⁵

Yet, arguably as important as who is responsible for day-to-day operation of health insurance exchanges is *who makes the rules* governing health insurance exchanges, for they control the extent of flexibility states

Out, BLOOMBERG BUS. (Dec. 14, 2012), <http://www.bloomberg.com/news/2012-12-14/obama-to-control-most-health-exchanges-as-states-opt-out.html>.

² Dash et al., *Implementing the Affordable Care Act*, *supra* note 1.

³ See, e.g., Jessica Bulman-Pozen, *From Sovereignty and Process to Administration and Politics: The Afterlife of American Federalism*, 123 YALE L.J. 1920, 1948 (2014); David K. Jones et al., *Pascal’s Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. HEALTH POL. POL’Y & L. 97 (2014); Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation*, 46 U. RICH. L. REV. 781, 796–803 (2012); Brendan W. Williams, *A Better “Exchange”: Some States, Including Washington, Control Their Health Care Markets While Most Surrender Autonomy to Resist Reform*, 48 GONZ. L. REV. 595, 610–615 (2013); *GOP States Offer Little Help to Health Care Exchanges*, CBS ATLANTA (Oct. 1, 2013), <http://atlanta.cbslocal.com/2013/10/01/gop-states-offer-little-help-to-health-care-exchanges/>; Elizabeth Hartfield, *Health Care Law: GOP Govs Opt Out of State Exchanges*, ABC NEWS (Nov. 15, 2012), <http://abcnews.go.com/blags/politics/2012/11/health-care-law-gop-govs-opt-out-of-state-exchanges/>.

⁴ See, e.g., *10 Reasons ObamaCare is a Government Takeover of Health Care*, GALEN GUIDE NO. 2 (Galen Inst., Alexandria, Va.), Fall 2012, at 1 (“States are being treated like contractors to the federal government, not sovereign entities empowered by the Constitution. They are ordered to set up new exchange bureaucracies lest the federal government sweep in and do it for them.”); Michael F. Cannon, *ObamaCare: A Federal Takeover, No Matter Who Runs the Exchanges*, CATO INST. (March 15, 2011), <http://www.cato.org/blog/obamacare-federal-takeover-no-matter-who-runs-exchanges> (“[U]nder ObamaCare the feds will write all the rules governing health insurance, so who administers the Exchanges is well-nigh irrelevant. ObamaCare is a federal takeover of health care, no matter who runs these new government bureaucracies that we call health insurance Exchanges.”).

⁵ For example, originally all states but Alaska applied for and received federal grants to support planning for exchange establishment. DASH ET AL., *IMPLEMENTING THE AFFORDABLE CARE ACT*, *supra* note 1, at 15.

running their own exchanges can have. Here, Congress put the federal government in the driver's seat by assigning the Secretary of the Department of Health and Human Services (HHS) responsibility for issuing regulations regarding, among other things, the "establishment and operation of Exchanges," "the offering of qualified health plans through such Exchanges," and "such other requirements as the Secretary determines appropriate."⁶ Reflecting the same federalism values that led to state-run exchange default,⁷ however, Congress also provided for a consultation role for state officials in the federal rulemaking process.⁸

This Article describes how this consultation provision was implemented in the four years that followed enactment of the ACA, as the initial policies and operational decisions governing health insurance exchange establishment were made. Given that Congress did not elaborate on how frequently the Secretary should consult with state representatives, the Secretary likely has discretion to keep her consultations largely pro forma and thus minimized state influence over federal policies. Yet complicating the traditional "federal takeover" narrative that has accompanied exchange implementation, this Article demonstrates that states actually played an active and influential role in federal decision-making processes.⁹

⁶ Patient Protection and Affordable Care Act § 1321(a)(1), 42 U.S.C. § 18041(a)(1) (2012).

⁷ See Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 *FORDHAM L. REV.* 1749, 1757 (2013) ("[E]xchange governance was the key question that divided the House and Senate versions of the legislation, with the Senate invoking 'federalism' values to insist on the state-leadership default preference that ultimately carried the day."); see also Gillian E. Metzger, *Federalism Under Obama*, 53 *WM. & MARY L. REV.* 567, 576 ("This reliance on state-run exchanges marks a significant difference between the Senate bill that became the ACA and the earlier House version. The latter had assigned primary responsibility for operating a national uniform exchange to the federal government, with states allowed to opt in to operate state-based exchanges if they met federal requirements. State officials lobbied strongly for state-based exchanges and for states to retain broad regulatory authority over insurance." (footnotes omitted)).

⁸ Patient Protection and Affordable Care Act § 1321(a)(2), 42 U.S.C. § 18041(a)(2) (2012).

⁹ This Article complements other work questioning descriptions of the ACA as a "federal takeover" of insurance regulation. Of note, Professors Brendan Maher and Radha Pathak have argued that the ACA provides "an opening for state actors to exploit and reclaim their historic preeminence with respect to health insurance

In doing so, this Article contributes to a growing field of literature regarding whether states should have a special role in or access to federal deliberations that impact their interests and, if so, how this should be manifested in administrative procedures and/or judicial review.¹⁰ The normative arguments most frequently proffered in favor of a special role for states, as summarized in a recent article by Professor Miriam Seifter, include: advancing federalism interests,¹¹ enhancing agency expertise,¹² and maintaining or enhancing democratic accountability.¹³ Critics do not necessarily challenge the desirability of these interests, but rather question the extent to which special procedural rules for states, in their current form or as proposed reforms, actually advance these interests in practice.¹⁴

regulation” by “incorporat[ing] state preferences, grow[ing] state regulatory markets, and provid[ing] possibilities for state regulators to attract millions more to their spheres of influence.” Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL’Y REV. 275, 306, 307 (2013).

¹⁰ See, e.g., Gillian E. Metzger, *Administrative Law As the New Federalism*, 57 DUKE L.J. 2023 (2008) (arguing that administrative law can be used to advance federalism); Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1 (2011) (arguing for judicial deference to agency interpretations that are born from bilateral intergovernmental bargaining); Miriam Seifter, *States, Agencies, and Legitimacy*, 67 VAND. L. REV. 443 (2014) (arguing that a robust state role in administrative decision-making could imperil administrative legitimacy without reform); Catherine M. Sharkey, *Federalism Accountability: “Agency-Forcing” Measures*, 58 DUKE L.J. 2125 (2009) (contending that, despite poor performance in the past, agencies can protect federalism interests if existing procedural rules are meaningfully enforced).

¹¹ Miriam Seifter, *States As Interest Groups in the Administrative Process*, 100 VA. L. REV. 953, 957 (2014) (“The most oft-cited goal of involving states in federal administration, mirroring a prevailing goal of contemporary federalism scholarship, is the protection of state power from federal excess.”).

¹² *Id.* (“[T]he idea is that state consultation will improve agencies’ decisions by conveying states’ local knowledge and experience as regulatory ‘laboratories.’”).

¹³ *Id.* (The idea “that states can be trusted with privileged access to agency decision making because, unlike private groups, states are ‘co-regulators’ and represent public constituencies themselves.”)

¹⁴ For example, in the same article, Professor Seifter argues that state interest groups frequently serve as state representatives to federal agencies, but that their involvement “inevitably requires tradeoffs among the core goals at the intersection of administrative law and federalism.” *Id.* at 956. In an earlier work, Professor Seifter has argued that there is no basis for assuming that states will advance expertise- or public-interest-based agendas, or that their demands will necessarily

Ultimately, many underlying assumptions behind positive and negative assessments of state influence turn on largely un-tested empirical questions, such as: What formal and informal channels do states use to engage in federal administrative decision-making? How frequently do states engage in federal decision-making processes? Who, in fact, represents states in these processes (executive or legislative branch officials, or state interest groups, e.g., the National Governors Association and National Conference of State Legislatures)? How much influence are any of these representatives able to exert?¹⁵

Relatively little work has been done to answer these questions to date.¹⁶ This Article intends to fill this gap by documenting state

reflect Congressional intent as others have opined. Seifter, *supra* note 10, at 491–501; *cf.* Nina A. Mendelson, *A Presumption Against Agency Preemption*, 102 NW. U. L. REV. 695, 718 (2008) (arguing that “[a]n institution with a specialized focus, an agency is not likely to possess the broader institutional mission, or the expertise necessary, to consider the appropriate balance of authority between the federal government and the states or the benefits of preserving some degree of state autonomy.”); Ryan, *supra* note 10, at 10–11 (arguing that the outcomes of bargaining between states and federal agencies should be considered a legitimate interpretation of federalism so long as the negotiations are based on mutual consent and federalism values, including the maintenance of checks and balances, accountability and transparency, preference for local innovation and competition, and problem-solving).

¹⁵ *Cf.* Metzger, *supra* note 10, at 2085 (referencing Nina A. Mendelson, *Chevron and Preemption*, 102 MICH. L. REV. 737, 758–59 (2004)) (“Professor Nina Mendelson has correctly insisted that the ability of states to protect their regulatory interests through notice-and-comment rulemaking is largely an empirical question, as are claims about the extent of state influence on federal agency decision-making.”).

¹⁶ Seifter, *supra* note 10, at 445 (“Scholars of the administrative process . . . have scarcely studied the state role in federal regulation.”). Notable exceptions include Professor Seifter’s subsequent article documenting state interest group engagement in federal administrative processes, Seifter, *supra* note 11; Catherine M. Sharkey, *Inside Agency Preemption*, 110 MICH. L. REV. 521 (2012) (examining five agencies’ efforts to comply with Executive Order 13,132 following issuance of President Obama’s Memorandum on Preemption); and JOHN D. NUGENT, *SAFEGUARDING FEDERALISM: HOW STATES PROTECT THEIR INTERESTS IN NATIONAL POLICYMAKING* (2009) (demonstrating how states promote their interests in both federal legislative and administrative processes). Additionally, for examples of work in the overlapping field of environmental law and administrative federalism, see Heather Gerken, *Federalism as the New Nationalism: An Overview*, 123 YALE L.J. 1889, 1902 n.86 (2014).

engagement in federal decision-making with respect to health insurance exchanges. In so doing, this Article relies on both formal written records evidencing state engagement in rulemaking and interviews with a number of state officials and state interest group representatives. While the interviews are not representative of every state or every state official's experience and perspective, they help cast light on informal state-federal agency relationships that are not captured as part of any lasting public record.¹⁷ And, while this Article cannot definitively say that state engagement was the "but-for" cause of final decisions by federal officials,¹⁸ the interviews herein provided insight into factors that likely affected how much influence states were able to exert.

Before proceeding into the research findings, Part II briefly describes the administrative procedural rules by which state and federal officials interacted. Given that the ACA did not elaborate on how federal officials should consult with states, federal officials were only legally constrained by pre-existing framework laws and orders governing administrative interactions with states. As Part II shall explain, despite multiple Executive Orders expounding the importance of considering state interests in federal rulemaking, existing law sets few formal requirements on agencies that appear to have any great impact on their actions. Indeed, perhaps most important to state-federal interactions is a provision of the Unfunded Mandates Reform Act of 1995, which facilitates off-the-record communication between federal officials and state officials.

Part III begins to fill the aforementioned research gap by examining actual state engagement in federal decisions governing exchange implementation. As mentioned above, it is informed by a review of publicly available materials, including public comments on federal rulemaking, and interviews with state officials and representatives of state interest groups, as well as two former federal officials, all of whom were active in exchange policymaking deliberations.¹⁹

This research suggests that states were given and took advantage of numerous opportunities, both formal and informal, to weigh in on exchange implementation.²⁰ In fact, state officials frequently spoke positively of the

¹⁷ Cf. Seifter, *supra* note 10, at 465.

¹⁸ Indeed, it has been observed that "measuring regulatory influence in any context is notoriously difficult." *Id.* at 473–74.

¹⁹ For a detailed discussion of methodology and limitations, see *infra* App. A.

²⁰ For clarity sake, this Article departs from the technical meanings of "formal" and "informal" under the Administrative Procedure Act (APA). Formal

federal government's willingness to work with them and accommodate their needs and preferences. The Center for Consumer Information and Insurance Oversight (CCIIO)—the office within the U.S. Department of Health and Human Services (HHS) charged with implementing the ACA's insurance reform provisions—received particular praise from states. Notably, state participation and positive experiences extended beyond the states that ultimately chose to operate their own exchanges: many states that may be commonly perceived as critics or opponents of exchanges because they chose to default to a federally run exchange and/or signed on to anti-ACA litigation nonetheless actively engaged in both formal and informal lobbying and developed close working relationships with federal officials.

Part IV discusses multiple factors that appeared to affect how much influence states could exert over federal decision-making. First, state officials frequently described how their ability to influence the federal government was connected to the extent to which the federal government perceived that the state shared the ACA's goals of increasing access to health coverage and expanding consumer protections in the insurance market. Second, restraints on federal financial resources and capacity appeared to both encourage and limit state influence in different ways. Third, institutional characteristics of the federal agencies and their different sub-components appeared to make them more or less amenable to state influence. Fourth, and finally, states could enhance their influence when they were able to act as first-movers.

Part V briefly discusses changing dynamics in health insurance exchange policy and politics and suggests that a continued reliance on informal processes could imperil state interests going forward. It concludes the Article by finding that while informality has arguably served state officials well to date, any gains acquired through informal processes can also be taken away without the federal government having to turn to any formal procedures. Accordingly, to the extent states want to secure any advances they have made, they may want to consider pushing for a more formal seat at the table in the future.

proceedings, as used here, generally refer to informal notice-and-comment rulemaking procedures under the APA. Informal proceedings refer to off-the-record communications between state and federal officials, which may occur by telephone or in-person at meetings.

II. THE ROLE OF STATES IN CURRENT ADMINISTRATIVE RULEMAKING PROCEDURES

The primary mechanism for stakeholders to engage in federal policymaking decisions is participation in notice-and-comment rulemaking. Stakeholders, including states, can learn of pending action, provide written comments either supporting or opposing the proposed rule, and encourage other parties who may share their interests, such as their congressional delegation, to weigh in as well.²¹ In light of the arguably special role of states, federal policymakers have also adopted various federalism-promoting procedural requirements to try to give special attention or access to state interests. Generally, though, these efforts are heavy on rhetoric regarding the importance of respecting state interests, while continuing to leave decisions about when and how to consult with states to the discretion of administrative officials.

Executive Order 12,372, Intergovernmental Review of Federal Programs (1982), broadly requires federal agencies to provide “opportunities for consultation” by state elected officials when they would be directly affected by proposed federal financial assistance or development programs.²² To effectuate this consultation requirement, federal agencies are told to communicate with state officials “as early in the program planning cycle as is reasonably feasible to explain specific plans and actions” and “make efforts” to accommodate any concerns states raise.²³

Executive Order 12,866, Regulatory Planning and Review (1993), expands the command to federal agencies to consult with state officials beyond federal programs (and beyond the limit that such officials be “elected”), providing that “[w]herever feasible, [federal] agencies shall seek views of appropriate State, local, and tribal officials before imposing regulatory requirements that might significantly or uniquely affect those governmental entities.”²⁴ Executive Order 12,866 also encourages agencies to consider using “consensual mechanisms for developing regulations,

²¹ Metzger, *supra* note 10, at 2086.

²² Exec. Order No. 12,372 § 1, 3 C.F.R. 197, 197 (1983) (as amended by Exec. Order No. 12,416, 3 C.F.R. 186 (1984)), *reprinted as amended in* 31 U.S.C. § 6506 (2012).

²³ *Id.* § 2(b), (c), 3 C.F.R. at 197.

²⁴ Exec. Order No. 12,866 § 1(b)(9), 3 C.F.R. 638, 640 (1994), *reprinted as amended in* 5 U.S.C. § 601 app. at 802—06 (2012).

including negotiated rulemaking.”²⁵ Negotiated rulemaking occurs when an advisory committee is convened to “consider and discuss issues for the purpose of reaching a consensus in the development of a proposed rule.”²⁶ An outside facilitator leads the process and any consensus is ultimately incorporated into a proposed rule that then goes through normal notice-and-comment rulemaking.²⁷ While not limited to such purposes, Professor Erin Ryan has argued that negotiated rulemaking “holds promise for facilitating sound administrative policymaking in disputed federalism contexts”²⁸ by ensuring “that agency personnel will be unambiguously informed about the full federalism implications of a proposed rule by the impacted state interests.”²⁹

Executive Order 13,132, Federalism (1999), goes another step further to state that “[t]he national government should be deferential to the States when taking action that affects the policymaking discretion of the States and should act only with the greatest caution where State or local governments have identified uncertainties regarding the constitutional or statutory authority of the national government.”³⁰ Specifically with respect to consultation, Executive Order 13,132 generally requires federal agencies to refrain from promulgating any rules that have “federalism implications” unless the federal government consults with state officials while developing the proposed rule and publishes a “federalism summary impact statement” describing such consultation and discussing any concerns raised by state officials.³¹

Finally, the Unfunded Mandates Reform Act of 1995 (UMRA) both limits federal imposition of financial burdens on states and strengthens the relationships between federal and state governments. While many of UMRA’s directives are targeted at Congress, the law also addresses federal

²⁵ *Id.* § 6(a)(1), 3 C.F.R. at 645.

²⁶ 5 U.S.C. § 562(7) (2012).

²⁷ *Id.* § 566.

²⁸ Ryan, *supra* note 10, at 51.

²⁹ *Id.* at 53. Ryan further notes that “state-side federalism bargainers” consistently reported a preference for negotiated rulemaking over traditional notice-and-comment rulemaking for this reason. *Id.* at 54.

³⁰ Exec. Order 13,132 § 2(i), 3 C.F.R. 206, 207 (2000), *reprinted as amended in* 5 U.S.C. 601 app. at 807–809 (2012).

³¹ *Id.* § 6, 3 C.F.R. at 209–10. However, if the regulation imposes substantial direct compliance costs on states but does not preempt state law, federal agencies may bypass these requirements if, instead, the federal governments pays such costs on behalf of the states. *Id.* § 6(b)(1), 3 C.F.R. at 209.

agencies in two ways. First, building on Executive Order 12,866, UMRA requires agencies to provide written statements detailing the costs and benefits of any “significant” federal mandate that may result in the expenditure by state, local, or tribal governments of at least \$100 million (adjusted annually for inflation) in any one year.³² Second, to promote free-flowing communication, UMRA requires agencies to develop an “effective process” for state elected officers, among others, to “provide meaningful and timely input in the development of regulatory proposals containing significant Federal intergovernmental mandates,”³³ and exempts meetings between federal officials and state elected officers and/or their designated employees from the requirements of the Federal Advisory Committee Act (FACA), such as notice and disclosure rules.³⁴

While these Executive Orders and UMRA give lip service to accommodating state interests and concerns, they arguably offer little by way of hard requirements. The rulemaking agency is generally given discretion regarding whether consultation is necessary or feasible. The rulemaking agency also is the entity to determine what the process of consultation should look like when it occurs, with minimal oversight of their decisions or practices.³⁵ Empirical research supports a finding that, at least historically, these requirements have had little teeth. For example, a study by Professor Nina Mendelson found that only six out of 600 proposed or final rules issued during one quarter of 2003 included or referred to a completed federalism impact analyses; an updated sampling in May 2006 delivered similar results. She further noted that, when federalism impact analyses were prepared, “[n]early all were of low quality, failing to analyze state interests in providing additional protection for residents, state autonomy, or any [other federalism values].”³⁶ Similarly, use of negotiated rulemaking by federal agencies remains rare:

³² Unfunded Mandates Reform Act of 1995 (UMRA), 2 U.S.C. § 1532 (2012).

³³ *Id.* § 1534(a).

³⁴ *Id.* § 1534(b).

³⁵ For example, under Executive Order 13,132, an agency must include a certification of compliance with the federalism requirements in a final rule that the agency has determined has federalism implications when such rule is otherwise subject to review prior to promulgation by the Office of Management and Budget under Executive Order 12,866. Exec. Order 13,132 § 8(a), 3 C.F.R. at 210; *see also* Sharkey, *supra* note 10, at 2177–78 (criticizing executive enforcement of Executive Order 13,132).

³⁶ Mendelson, *supra* note 14, at 718–19 (2008) (referencing Mendelson, *supra* note 15, at 771, 782–83).

according to Professor Erin Ryan, “in the first thirteen years surrounding passage of the Negotiated Rulemaking Act, only fifty federal rules were produced through negotiated rulemaking—as little as one percent of the total number of rules promulgated over this period.”³⁷

The tide may have begun to turn, at least temporarily, under President Obama, however. Shortly after taking office, he issued a memorandum to his agency heads encouraging precaution when regulations could preempt state law and careful compliance with Executive Order 13,132.³⁸ The memorandum reportedly “led to serious internal review” and policy changes within at least some federal agencies, including the National Highway Traffic Safety Administration and the Consumer Product Safety Commission.³⁹

Additionally, the potential impact of UMRA’s exception of state officials from FACA should not be dismissed. While it does not require state engagement in federal policymaking, it can give state officials privileged access to federal policymakers as rules are being developed. Based on in-depth studies of state interactions with the Environmental Protection Agency, Professor Miriam Seifter has observed that state influence largely “appears to come through states’ informal and largely subterranean consultations with agencies--through agency-state ‘workgroups,’ meetings, and regular conference calls arising from states’ status as ‘co-regulators’ in federal programs.”⁴⁰

Outside the scope of formal rules, states may also use their unique public position and authority to sway federal regulators. For example, state officials may attempt to leverage their congressional delegations to gain influence. Federal agencies are particularly responsive to members of Congress and, given legislators’ responsiveness to their home state governments, “[a]gency officials’ desire to please important constituencies in Congress thus will lead them to seek to please the governments of the states with home they deal.”⁴¹ Similarly, state officials may “adopt public

³⁷ Ryan, *supra* note 10, at 55.

³⁸ Preemption: Memorandum for the Heads of Executive Departments and Agencies, 74 Fed. Reg. 24,693 (May 20, 2009).

³⁹ CATHERINE M. SHARKEY, ADMIN. CONFERENCE OF THE U.S., FEDERAL AGENCY PREEMPTION OF STATE LAW: EXECUTIVE SUMMARY 2, *available at* <http://www.acus.gov/sites/default/files/documents/Sharkey-Executive-Summary.pdf>.

⁴⁰ Seifter, *supra* note 10, at 461.

⁴¹ Samuel R. Bagenstos, *Federalism by Waiver After the Health Care Case*, in PUBLIC LAW AND LEGAL THEORY RESEARCH PAPER SERIES 6 (2012).

relations campaigns to draw attention to their disagreements with proposed or existing federal policies, exhorting policymakers to act in a more state-friendly way.”⁴² State and federal officials also may vie for policymaking control over a given area and put out competing regulations. When facing a state that has already taken action in an area, the federal government may simply acquiesce to their policy decisions rather than attempt to preempt them.⁴³

III. STATE ENGAGEMENT IN FEDERAL DECISION-MAKING ON EXCHANGES

This Part discusses different channels and methods states used to influence federal rules and guidance on or related to exchange implementation. It finds that states, including those that did not elect to operate state-based exchanges, were actively involved in this process through both formal and informal channels. The federal government provided numerous opportunities for states to weigh in through notice-and-comment rulemaking and other solicitations published in the *Federal Register*, and states frequently responded with detailed letters expressing their preferences and concerns. Of even greater value to states was the near constant informal communications between states and federal officials. States also regularly relied on state interest groups, like the National Association of Insurance Commissioners (NAIC), and informal cross-state collaboration to amplify their voices through both formal and informal communication channels.

A. FORMAL ENGAGEMENT: NOTICE-AND-COMMENT RULEMAKING

The federal government has engaged in frequent rulemaking with respect to health insurance exchanges between March 23, 2010 and May 30, 2014. The following sections discuss this process as well as the response from states to opportunities to provide comments.

⁴² NUGENT, *supra* note 16, at 58.

⁴³ Professor Erin Ryan has referred to this as “intersystemic signaling.” Ryan, *supra* note 10, at 70.

1. Federal Use of Notice-and-Comment Rulemaking

Since enactment of the ACA, the federal government has published more than forty actions in the *Federal Register* directly or tangentially related to the establishment or operation of exchanges.⁴⁴ The Centers for Medicare & Medicaid Services (CMS), within HHS, is the most frequent publisher, although some actions have come out of the Internal Revenue Service (IRS) or directly from HHS.⁴⁵

Prior to engaging in any rulemaking related to exchanges, the federal government issued a request for comments soliciting input on twelve topics: state exchange planning and establishment grants, implementation timeframes and considerations, state exchange operations, qualified health plans (QHPs), quality, an exchange for non-electing states, enrollment and eligibility, outreach, rating areas, consumer experience, employer participation and risk adjustment reinsurance, and risk corridors.⁴⁶ While all stakeholders were invited to respond, many of the questions were either explicitly targeted at soliciting state views on their

⁴⁴ See *infra* App. A.

⁴⁵ The first action, requesting comments regarding exchanges, was published by the Office of Consumer Information and Insurance Oversight, within HHS. Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 45,584 (Aug. 3, 2010) (to be codified at 45 C.F.R. pt. 170). This independent office was subsequently converted into the Center for Consumer Information and Insurance Oversight (CCIIO) and placed under CMS's jurisdiction. Arthur D. Postal, *HHS Overhauls Consumer Office*, LIFEHEALTHPRO (Jan. 6, 2011), <http://www.lifehealthpro.com/2011/01/06/hhs-overhauls-consumer-office>.

⁴⁶ Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 45,586–90.

needs and preferences,⁴⁷ or requested information about state policies and operations.⁴⁸

Subsequently, the federal government solicited formal comments twenty-seven times on issues broadly related to exchange implementation.⁴⁹ Most (eighteen) of these opportunities were in the form of proposed rules or notices of proposed rulemaking, allowing interested parties to provide comments before anything was finalized. One was a request for information regarding health care quality standards for plans offered through exchanges. In an additional two cases, CMS issued notices in the *Federal Register* soliciting comments on potential action it was considering (specifically, recognizing a new organization as an accrediting entity for the purpose of QHP certification and developing a sound framework for rating the quality of QHPs).

In five cases, the government solicited comments on interim final rules.⁵⁰ While the public had an opportunity to provide comments, the interim final provisions (which in some cases encompassed the whole rule, and in others were just sections of a rule that otherwise was being finalized without an additional comment opportunities) were finalized and scheduled to go into effect before consideration of any comments. In many of these instances, the federal government departed significantly from an approach raised in the proposed rule, but found cause to finalize the new language without going through another round of notice-and-comment rulemaking.⁵¹

⁴⁷ *E.g., id.* at 45,586 (“What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014?”); *id.* at 45,587 (“What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment?”); *id.* at 45,588 (“What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?”).

⁴⁸ *E.g., id.* at 45,588 (“To what extent do States currently have similar requirements or standards for plans in the individual and group markets?”); *id.* at 45,589 (“To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)?”); *id.* (“To what extent do States currently offer reinsurance in the health insurance arena (e.g., Medicaid, State employee plans, etc.) or in other arenas?”).

⁴⁹ *See infra* App. B.

⁵⁰ *Id.*

⁵¹ For example, in the final and interim final rules on exchange establishment, HHS notes, “Based on the comments that we received on the Exchange

In one instance, the IRS issued a final regulation but solicited additional written comments on subject matter to be addressed through future rulemaking.⁵²

The comment periods for actions released in 2010 and 2011 were all at least sixty days in length, while many of the later rules provided much shorter comment periods (Table 1). At the most extreme, one interim final rule provided for only a six-day comment period.⁵³ More common were comment periods between twenty-one and thirty days in length.⁵⁴ Rules would often also come out in batches, with multiple rules published on or around the same day.⁵⁵ While this provided the public a more comprehensive understanding of the issues under development, it also increased the amount of work for respondents in that time period. Indeed, after the federal government released five major exchange-related regulations over a one-month time period in the summer of 2011, it bowed

establishment and eligibility proposed rules, we believe that there are new options and specific standards that should be implemented in connection with eligibility determinations.” Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,434 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155,156, 157). However, citing timing constraints and concerns that “it would be contrary to the public interest to delay issuing new eligibility determination and timeliness standards,” HHS chose to waive proposed rulemaking. *Id.*

⁵² Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,380 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602) (“The final regulations authorize the Commissioner to publish additional guidance, see § 601.601(d)(2), to address the effect on affordability of wellness incentives that increase or decrease an employee’s share of premiums. Comments are requested on types of wellness incentives, how these programs affect the affordability of eligible employer-sponsored coverage for employees and related individuals, and how incentives are earned and applied.”).

⁵³ Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76,212, 76,212 (Dec. 17, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156). This rule, published on December 17, 2013 (although available for review online briefly beforehand), changed the effective coverage date for any QHP purchased through a federally facilitated exchange between December 15, 2013 and December 23, 2013 from February 1, 2014 to January 1, 2014. The rule provided states operating their own exchanges with the authority to make a similar change as well. *Id.* at 76,213–14.

⁵⁴ *See infra* App. B.

⁵⁵ *Id.*

to public pressure and extended the comment period on the initial rules from seventy-five to 108 days.⁵⁶ Sometimes comments were due over major holidays. For example, in the winter of 2012, deadlines for two proposed rules and one request for information fell on or between December 26, 2012 and December 31, 2012.⁵⁷

Table 1. Length of Exchange-Related Comment Periods by Year

Solicitation and Issuing Agency*	Action	Days
2010		
OCIO: Exchange-Related Provisions in Title I of the ACA	RFC	62
2011		
CMS/Treas: Application, Review, & Reporting Process for Waivers for State Innovation	PR	60
HHS: Establishment of Exchanges & QHPS	PR	108^
HHS: Standards Related to Reinsurance, Risk Corridors, & Risk Adjustment	PR	108^
HHS: Exchange Functions in the Indiv. Market; Elig. Determinations; Standards for Employers	PR	75
CMS: Medicaid Program; Elig. Changes Under the ACA	PR	75
IRS: Health Insurance Premium Tax Credit	NPRM	75
2012		
CMS: Medicaid Program; Elig. Changes Under the ACA	FR/IF R	45
HHS: Establishment of Exchanges & QHPs; Exchange Standards for Employers	FR/IF R	45
IRS: Health Insurance Premium Tax Credit	FR	90
HHS: Recognition of Entities for the Accreditation of QHPs	PR	30
HHS: Standards Related to Essential Health Benefits, Actuarial Value, & Accreditation	PR	30
CMS: Health Care Quality for Exchanges	RFI	30

⁵⁶ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Extension of Comment Period, 76 Fed. Reg. 60,788, 60,788–89 (Sept. 30, 2013) (to be codified at 45 C.F.R. pts. 153, 155, 156). Notably, this extension was announced mere days before the original due date for comments on the exchange establishment and risk adjustment proposed rules.

⁵⁷ See *infra* App. B.

Solicitation and Issuing Agency*	Action	Days
CMS: HHS Notice of Benefit & Payment Parameters for 2014	PR	24
2013		
CMS: EHB in Alternative Benefit Plans, Elig. Notices, Fair Hearing & Appeal Processes for Medicaid & Exchange Elig. Appeals & Other Provisions	PR	22
CMS: Exchange Functions: Elig. for Exemptions; Misc. Min. Essential Coverage Provisions	PR	45
CMS: Amdts. to the HHS Notice of Benefit & Payment Parameters for 2014	IFR	50
CMS: Establishment of Exchanges & QHPs; Small Business Health Options Program	PR	21
CMS: Exchange Functions: Standards for Navigators & Non-Navigator Assistance Personnel	PR	31
IRS: Min. Value of Eligible Employer-Sponsored Plans & Other Rules	NPRM	60
CMS: Program Integrity: Exchange, SHOP, Premium Stabilization Prgms & Market Standards	PR	30
IRS: Information Reporting for Affordable Insurance Exchanges	NPRM	63
CMS: AAAHC App. To Be a Recognized Accrediting Entity for the Accreditation of QHPs	N	32
CMS: Exchanges & QHPs, Quality Rating System, Framework Measures & Methodology	N	63
CMS: HHS Notice of Benefit & Payment Parameters for 2015	PR	24
CMS: Maximizing January 1, 2014 Coverage Opportunities	IFR	6
2014		
CMS: Third Party Payment of QHP Premiums	IFR	60
CMS: Exchange & Insurance Market Standards for 2015 & Beyond	PR	31

* Regulation names are shortened for brevity. A full list of exchange-related solicitations and rulemaking is available in Appendix B.

^ The original comment period for this proposed rule was seventy-five days. However, the federal government subsequently extended it to 108 days. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Extension of Comment Period, 76 Fed. Reg. 60,788, 60,788–89 (Sept. 30, 2011) (to be codified at 45 C.F.R. pts. 153, 155, 156).

FR = Final Rule

IFR = Interim Final Rule

N = Notice (with comment)

NPRM = Notice of Proposed Rulemaking

PR = Proposed Rule

RFC/RFI=Request for Comments/Information

The federal government has conducted an immense amount of rulemaking in the past four years—as one state official commented in an interview, “the speed with which [CMS] get[s] out regulations is astonishing . . . it took them five years to issue some of the interim final regulations for HIPAA.”⁵⁸ However, as much if not more information has been released only as sub-regulatory guidance documents. Guidance documents listed under the “Health Insurance Marketplaces” (the federal government’s term for health insurance exchanges) and “Plan Management” sections of CCIIO’s “Regulations and Guidance” webpage vastly outnumber regulations, which include both proposed and final versions of many rules,⁵⁹ and hundreds if not thousands of additional resources targeted towards states and insurance companies are only available on password protected websites.⁶⁰ While a few guidance documents include solicitations for comments,⁶¹ transparency-and-deliberation-forcing rules in the Administrative Procedure Act (APA) do

⁵⁸ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

⁵⁹ Ctr. for Consumer Info. & Ins. Oversight, *Regulations and Guidance*, CMS.GOV, <http://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html> (last visited May 14, 2014).

⁶⁰ See COLLABORATIVE APPLICATION LIFECYCLE TOOL (CALT), <https://calt.cms.gov/> (last visited May 21, 2015); REGISTRATION FOR TECHNICAL ASSISTANCE PORTAL (REGTAP), <https://www.regtap.info> (last visited May 22, 2015) (unlike CALT and SERVIS, members of the public can register to access REGTAP); STATE EXCHANGE RESOURCE VIRTUAL INFORMATION SYSTEM (SERVIS), <https://servis.cms.gov/resources/> (last visited May 14, 2014).

⁶¹ See, e.g., CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES (May 16, 2012), *available at* <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf>; Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Mar. 1, 2013), *available at* <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-3-1-2013.pdf>.

not apply, so the federal government is under no obligation to consider or publish feedback.⁶²

2. Federalism Analyses in Rulemaking

In the majority (thirty) of *Federal Register* publications, the federal government has included an explicit Federalism Impact Statement.⁶³ Examining federalism discussions in final and interim final rulemaking specifically, however, demonstrates some inconsistency in how the requirements of Executive Order 13,132 are met (Table 2). First, while CMS and HHS addressed the federalism implications of its rules either in an explicit Federalism Impact Statement or briefly within a more general Regulatory Impact Statement, the IRS did not include any references to federalism generally or Executive Order 13,132 specifically in any of its exchange-related rulemaking, including regulations enacting information reporting requirements on state-run exchanges.⁶⁴

Table 2. Federalism Impact Statements and Related Findings in Exchange-Related Final and Interim Final Rules

Rule*	FIS	EO 13132 Compliance Certified or Attested	EO 13,132-Related Findings		
2012					
CMS/Treas: App., Review, & Reporting Process for Waivers for State Innovation	N	--	N	--	--
CMS: Medicaid Program; Elig. Changes Under the ACA (Final Rule/IFR)	Y	Neither	Y	--	--
HHS: Standards Related to	N	--	--	--	--

⁶² 5 U.S.C. § 553(b)(3)(A) (2012).

⁶³ See *infra* App. B.

⁶⁴ Information Reporting for Affordable Insurance Exchanges, 79 Fed. Reg. 26113 (May 7, 2014) (to be codified at 26 C.F.R. pt. 1).

Rule*	FIS	EO 13132 Compliance Certified or Attested	EO 13,132-Related Findings		
Reinsurance, Risk Corridors & Risk Adjustment					
HHS: Establishment of Exchanges & QHPS; Exchange Standards for Employers (Final Rule/IFR)	Y	Cert'd	N^	--	Y
IRS: Health Insurance Premium Tax Credit (2012)	N	--	--	--	--
HHS: Data Collection to Support Standards Related to EHBs; Recognition of Entities for the Accreditation of QHPs	Y	Cert'd	N	N	N
2013					
IRS: Health Insurance Premium Tax Credit (2013)	N	--	--	--	--
HHS: Standards Related to EHBs, Actuarial Value, and Accreditation	Y	Neither	N	Y	Y
CMS: HHS Notice of Benefit & Payment Parameters for 2014	Y	Attested	N	--	Y
CMS: Amdts. to the HHS Notice of Benefit & Payment Parameters for 2014 (IFR)	N	--	N	N	Y
CMS: Establishment of Exchanges & QHPs; Small Business Health Options Program	Y	Cert'd	N	N	N
CMS: Exchange Functions: Elig. for Exemptions; Misc. Min. Essential Coverage Provisions	Y	Cert'd	N	--	Y
CMS: EHB in Alternative Benefit Plans, Elig. Notices, Fair Hearing & Appeal Processes, & Premiums & Cost	Y	Cert'd	N	--	Y

Rule*	FIS	EO 13132 Compliance Certified or Attested	EO 13,132-Related Findings		
Sharing; Exchanges: Elig. & Enrollment					
CMS: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel	Y	Both	--	Y	--
CMS: Program Integrity: Exchange, SHOP, & Elig. Appeals	Y	Both	Y	Y	Y
CMS: Program Integrity: Exchange, Premium Stabilization Programs, & Market Standards	Y	Both	Y	Y	Y
CMS: Maximizing Jan. 1, 2014 Coverage Opportunities (IFR)	Y	Cert'd	N^	N	N
2014					
CMS: HHS Notice of Benefit & Payment Parameters for 2015	Y	Attested	N	--	Y
CMS: Third Party Payment of QHP Premiums (IFR)	Y	Cert'd	N^	N	N
IRS: Info. Reporting for Exchanges (2014)	N	--	--	--	--
CMS: Exchange and Insurance Market Standards for 2015 & Beyond	Y	Both	--	Y	--
Totals	15	13	3	5	9

* Unless otherwise noted, all rules were issued as final. Regulation names are shortened for brevity. A full list of exchange-related solicitations and rulemaking is available in Appendix B.

^ In these rules, the drafters limited their finding by noting that the rule does not impose any costs on state or local governments not otherwise imposed by already-finalized provisions of the regulations implementing the Affordable Care Act.

Second, even when CMS and HHS frequently included a discussion of federalism concerns, they did not appear to apply consistent processes for confirming that they were complying with the Executive Order. For example, federalism was usually discussed in a Federalism Impact Statement, but on two instances regulators only briefly dismissed any federalism concerns within the Regulatory Impact Statement.⁶⁵ In addition, where a Federalism Impact Statement was included, HHS usually attested or certified that CMS had complied with the requirements of the Executive Order in a meaningful and timely manner. On two instances, however, compliance was not confirmed despite findings that the rule either imposed direct costs on states⁶⁶ or that it had preemption and other federalism implications.⁶⁷

Third, CMS and HHS frequently did not address all three prongs of the standard used to determine whether certain requirements of the Executive Order applied to a given rule. The standard, as interpreted by HHS, asks whether a rule 1) imposes substantial direct costs on State and local governments; 2) preempts State law, or 3) otherwise has federalism implications.⁶⁸ Most frequently, the federal government would find that a rule had federalism implications “due to direct effects on the distribution of power and responsibilities among the State and Federal governments.”⁶⁹ Sometimes, this finding was accompanied by a statement that the rule did not impose substantial costs on states or preempt state law, but frequently one or the other (most often, the preemption analysis) was not addressed

⁶⁵ Application, Review, and Reporting Process for Waivers for State Innovation, 77 Fed. Reg. 11,700, 11,714–15 (Feb. 27, 2012) (to be codified at 45 C.F.R. pt. 155); Patient Protection and Affordable Care Act, Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,541, 15,550 (Mar. 11, 2013) (to be codified at 48 C.F.R. pts. 153, 156).

⁶⁶ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144, 17,202 (Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 437).

⁶⁷ Patient Protection and Affordable Care Act, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,864 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

⁶⁸ See, e.g., Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,443–44 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155–57).

⁶⁹ *Id.*

one way or another. On two instances, the rules only addressed the preemption analysis and ignored the other two prongs.

Notably, the federal government more frequently acknowledged the preemptive effects and costs of rules that were issued later in the implementation process. In at least some cases, these later rules found such implications even though earlier rules on the same topics had not.⁷⁰ For example, while the 2012 final rule on standards related to reinsurance, risk corridors, and risk adjustment (collectively referred to as “premium stabilization programs”) did not include any discussion of federalism,⁷¹ the Federalism Impact Statement in the October 2013 final rule on these programs found that the rule would impose direct costs on states as “State-operated reinsurance and risk adjustment programs are required to undertake oversight, record maintenance and reporting activities.”⁷² Similarly, while the March 2012 rule on exchange establishment included standards for navigator programs,⁷³ the potential preemptive effect of these rules was not discussed until subsequent rulemaking in July 2013 and May 2014.⁷⁴

⁷⁰ The statements, however, were largely consistent from proposed to final rules, in contrast to earlier research documenting that agencies often only acknowledged any preemptive effects in final rather than proposed rules. Sharkey, *supra* note 32, at 2139.

⁷¹ Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220 (Mar. 23, 2012) (to be codified at 45 C.F.R. pt. 153).

⁷² Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 65,046, 65,091 (Oct. 30, 2013) (to be codified at C.F.R. pts. 144, 146, 147).

⁷³ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,330–34, 18,443 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, 157).

⁷⁴ Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors; Final Rule, 78 Fed. Reg. 42,824, 42,858–59 (July 17, 2013) (to be codified at 45 C.F.R. pt. 155); Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 Fed. Reg. 30240, 30,333–35 (May 27, 2014) (to be codified at 45 C.F.R. pts. 144, 146, 147).

3. State Participation in Notice-and-Comment Rulemaking

In the case of exchange implementation, many states were in fact fairly active in the commenting process.⁷⁵ Discounting five rules or notices for which no states submitted comments,⁷⁶ an average of between thirteen and fourteen states submitted either individual or joint comments on each exchange-related action. This, however, glosses over significant variability across solicitations.

The action on which the greatest number of states (forty-one, including the District of Columbia) submitted comments was a proposed rule titled, “Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing.”⁷⁷ As indicated by the name, this was an “omnibus” rule covering a wide range of issues and it elicited comments from a number of state agencies or offices that did not normally participate in the exchange rulemaking process, such as administrative hearing

⁷⁵ See *infra* App. B.

⁷⁶ Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,380 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602); Patient Protection and Affordable Care Act, Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,541 (Mar. 11, 2013) (to be codified at 45 C.F.R. pts. 153, 156); Patient Protection and Affordable Care Act, Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 15,553 (proposed Mar. 11, 2013) (to be codified at 45 C.F.R. pts. 155, 156); Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans, 78 Fed. Reg. 56,711 (Sept. 13, 2013); Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76,212 (Dec. 17, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

⁷⁷ Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; 78 Fed. Reg. 4,594 (proposed Jan. 22, 2012) (to be codified at 42 C.F.R. pts. 430, 431, 433, 435, 440, 447, 457, 45 C.F.R. pt. 155).

offices.⁷⁸ Other highly commented on rules included the initial exchange establishment proposed rule⁷⁹ (thirty-five states, including the District of Columbia) and the Medicaid eligibility proposed rule⁸⁰ (thirty-eight states, including the District of Columbia) (which states sometimes responded to with a single set of joint comments⁸¹), and the recent proposed rule Exchange and Insurance Market Standards for 2015 and Beyond⁸² (twenty-five states, including the District of Columbia). Twenty states responded to the initial request for comments on exchanges,⁸³ which as discussed above, was largely targeted towards soliciting state-specific responses. Curiously, only six states responded to the proposed rule on the application, review, and reporting process for state innovation waivers.⁸⁴

⁷⁸ See, e.g., Comments of the D.C. Office of Admin. Hearings on Proposed 45 CFR Part 155, Subpart F (Feb. 21, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0511>; Comments of Michael Zimmer, Exec. Dir., Mich. Admin. Hearings Sys., on Proposed 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457, and 45 CFR Part 155 (Feb. 21, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0397>; Comments of Tracy L. Henry, Chief A.L.J., Penn. Dep't of Pub. Welfare, Bureau of Hearings & Appeals (BHA) on Proposed Rule on Medicaid, CHIP and Exchanges (Feb. 21, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0522>.

⁷⁹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866 (proposed July 15, 2011) (to be codified at 45 C.F.R. pts. 155, 156).

⁸⁰ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51,148 (proposed Aug. 17, 2011) (to be codified at 42 C.F.R. pts. 431, 433, 435, 457).

⁸¹ See, e.g., The State of Utah's Comments on Proposed Federal Rules Relating to the Implementation of Exchanges Under the Affordable Care Act (Oct. 31, 2011), available at <http://www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0020-2287> (responding to five distinct proposed rules issued between July 15 and Aug. 17, 2011).

⁸² Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 Fed. Reg. 15,808 (proposed Mar. 21, 2014) (to be codified at 45 C.F.R. pts. 146, 147, 149, 153, 155, 156, 158).

⁸³ Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 45,584 (Aug. 3, 2010) (to be codified at 45 C.F.R. pt. 170).

⁸⁴ Application, Review, and Reporting Process for Waivers for State Innovation, 75 Fed. Reg. 13,553 (proposed Mar. 14, 2011) (to be codified at 45 C.F.R. pt. 155).

Based on their response rates, this Article classifies twenty-one states as “infrequent participants” in rulemaking, submitting comments four or fewer times (Table 3). Of these, only one state (Delaware) did not respond to any solicitations, however. Sixteen states and the District of Columbia may be classified as “moderate participants,” responding to between five and nine solicitations, while thirteen states may be classified as “frequent participants,” responding to ten or more solicitations. Unsurprisingly, states operating state-based exchanges (New York and Oregon) were the most frequent commenters, responding to sixteen and fifteen solicitations, respectively. An additional six states operating state-based exchanges—California (fourteen), Colorado (eleven), Maryland (eleven), Massachusetts (twelve), Minnesota (twelve), and Washington (twelve)—commented on ten or more publications. Utah, which is operating its own state-based small business exchange, also commented on ten actions. Perhaps more surprisingly, some states that opted to defer to take no part in exchange operation were also actively engaged throughout the notice-and-comment process, including Louisiana (eleven), Oklahoma (eleven), Tennessee (ten), and Wisconsin (eleven). In addition, some states that either operated their own exchanges or formally partnered with the federal government largely opted out of formal commenting process, including Delaware (zero), Hawaii (two), Idaho (four), Kentucky (two), and New Hampshire (three).

Table 3. State Responses to Federal Exchange Solicitations

State (Frequency of Participation)	
Frequent Commenter	CA (14x), CO (11x), LA (11x), MD (11x), MA (12x), MN (12x), NY (16x), OK (11x), OR (15x), TN (10x), UT (10x), WA (12x), WI (11x)
Moderate Commenter	AL (7x), AZ (7x), AR (6x), DC (7x), IL (6x), IN (7x), IA (5x), ME (6x), MI (8x), NE (5x), NV (9x), NM (6x), OH (7x), RI (6x), TX (8x), VT (6x), WV (5x)
Infrequent Commenter	AK (3x), CT (3x), DE (0x), FL (2x), GA (4x), HI (2x), ID (4x), KS (4x), KY (2x), MS (2x), MO (2x), MT (1x), NH (3x), NJ (4x), NC (2x), ND (3x), PA (3x), SC (2x), SD (4x), VA (2x), WY (1x)

State-Based Exchange

State Partnership Exchange

Federally Facilitated Exchange (including Marketplace Plan Management States)

Bifurcated Exchange

In interviews, officials from states that were moderate or frequent commenters noted that they primarily submitted comments to establish a

formal record of their opinion.⁸⁵ State officials doubted, however, that the commenting would be enough to change an outcome on its own.⁸⁶ One official from a state with a federally run exchange appraised things by noting that, “[o]ur comments are lumped in with hundreds, if not thousands, of others, so it is probably not the most effective way of influencing the process, but it is one way and we certainly took advantage of that avenue.”⁸⁷ Some state officials noted that they would often rely on the NAIC to represent their interests—as one related, “I think they pay attention to NAIC. From individual states, it depends on what they’re saying.”⁸⁸ Capacity also presented a barrier to commenting for some states: “it was all we could do to operationalize our exchange and keep up with the federal rules as best we could We didn’t have time to be concerned about providing comments.”⁸⁹

State officials quickly pivoted from discussion of their approach to rulemaking to the other avenues they used to weigh in and often found to be more effective direct interaction with federal officials, whether over the

⁸⁵ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

⁸⁶ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld). *But see* Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld) (“[T]hey would seriously consider our comments and they would take the comments whenever they could.”); Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld) (“[T]he comments are taken very seriously by the feds. . . . Unless something goes in in formal comments it doesn’t get counted.”).

⁸⁷ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

⁸⁸ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

⁸⁹ Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld).

phone, in person, or by email.⁹⁰ A former federal official echoed their sentiments: “The comments are important, and we would always ask for thoughts in writing. But the more interactive process was more important.”⁹¹ A formal comment letter from Tennessee on the initial health insurance premium tax credit proposed rule reflects the idea that the direct interactions are where the action is as well as states’ interest in establishing a formal record of those interactions.⁹² Specifically, regulators included copies of letters and email communications sent between state and federal officials regarding, among other things, negotiations over whether and how to allow Medicaid Managed Care Organizations (MCOs) to offer products on exchanges.⁹³ Putting these conversations in the *formal* public record may be seen as a way to hold federal officials accountable to their off-the-record commitments.

⁹⁰ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

⁹¹ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

⁹² Darin J. Gordon, TennCare Dir. & Deputy Comm’r, Div. of Health Care Fin. & Admin., State of Tennessee’s Comments on Proposed Rules about Eligibility for Premium Tax Credits and Cost-Sharing Subsidies (Oct. 28, 2010), *available at* <http://www.regulations.gov/#!documentDetail;D=IRS-2011-0024-0072>.

⁹³ *Id.* at 14, 16–17, 19–32.

B. INFORMAL ENGAGEMENT: DIRECT AND INDIRECT COMMUNICATION

In this section, the Article discusses additional channels used by states to informally influence federal decisions on exchange implementation. Direct communication between state and federal officials—in person, over the phone, and by email—was common and valued by state officials. Some states also chose to bring in third parties, including members of Congress and the media, to pressure the federal government when state officials felt they were not making headway. In some cases, states were also able to take advantage of their first-mover status: having acted on an issue before the federal government had finalized its decision-making, states were able to ensure that any subsequent federal action accommodated their preferences.

1. Direct Communication

On July 29, 2010, the first allotment of federal grant funding for the planning and establishment of exchanges (known as “section 1311 funds”) was opened to states.⁹⁴ According to a former federal official, HHS began holding forums with state officials shortly thereafter.⁹⁵ Every state, except Alaska, subsequently applied for, at least some, exchange grant funding,⁹⁶ and the grant application and monitoring process has provided a critical opportunity for state-federal interaction. Before each grant cycle, states could participate in pre-application conference calls, during which federal officials would provide information about the project and offer policy and budgetary guidance.⁹⁷ Grant recipients were assigned a state

⁹⁴ OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE ACT’S EXCHANGES (July 29, 2010), *available at* https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/exchange_planning_grant_foa.pdf.

⁹⁵ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

⁹⁶ Ctr. for Consumer Info. & Ins. Oversight, *Creating a New Competitive Health Insurance Marketplace*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Marketplace-Grants/index.html> (last visited May 22, 2015).

⁹⁷ *See, e.g.*, OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., COOPERATIVE AGREEMENT TO SUPPORT ESTABLISHMENT OF STATE-OPERATED HEALTH INSURANCE EXCHANGES 13–14

officer to track their progress and provide technical assistance as needed,⁹⁸ and CCIIO held at least two multi-day meetings in Washington, D.C. with grantees during which federal officials would review policy and operational issues.⁹⁹

State officials from both states operating state-based exchanges and states with partnership and fully federally run exchanges reported that their state officers became their primary contact point at HHS.¹⁰⁰ Depending on the proximity to the initial open enrollment period beginning in October 2013, state officials would be interacting with their state officer on a daily or weekly basis.¹⁰¹ As needed, state officers would funnel questions or

(Jan. 20, 2011), *available at* http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/foa_exchange_establishment.pdf.

⁹⁸ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., COOPERATIVE AGREEMENT TO SUPPORT ESTABLISHMENT OF THE AFFORDABLE CARE ACT'S HEALTH INSURANCE EXCHANGES 43 (Dec. 6, 2013), *available at* <http://www.cms.gov/CCIIO/Resources/FundingOpportunities/Downloads/amended-spring-2012-establishment-foa.pdf>.

⁹⁹ *See, e.g.*, Ctr. for Consumer Info. & Ins. Oversight, *Affordable Insurance Exchanges: State Exchange Grantee Meeting: September 19–20, 2011*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Presentations/hie-fall-2011-grantee-meeting.html> (last visited May 22, 2015); Ctr. for Consumer Info. & Ins. Oversight, *Affordable Insurance Exchanges: System-Wide Exchange Meeting: May 21–23, 2012*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Presentations/hie-spring-2012-conference.html> (last visited May 22, 2015).

¹⁰⁰ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰¹ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity

concerns to policy and legal staff within CCIIO, CMS, or IRS, or set up calls so they could directly communicate with states.¹⁰² One state official also noted that their state officer would tip them off on when to escalate an issue to a higher level because they were not getting traction.¹⁰³

As implementation moved forward, higher-level officials at CCIIO and CMS would also hold regular calls with state officials, including weekly meetings with the directors of state-based exchanges.¹⁰⁴ The federal government also continued to hold or attend multi-state meetings where states could schedule “office hours” visits with federal officials to discuss different policy options.¹⁰⁵ According to one state official, “states that wanted to be involved took advantage [of these meetings]. We wanted to interact with HHS as much as we could.”¹⁰⁶

State officials indicated that the informal nature of these interactions was valuable, particularly with respect to operational questions. According to one official, “it is much easier to talk about things informally rather than put in writing that you can’t complete a legal requirement . . . CMS played an important advisory role and problem solving role that wouldn’t have been possible through formal rules.”¹⁰⁷ Another official noted that they appreciated the ability to form a close

and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

¹⁰² *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰³ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹⁰⁴ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with former federal official (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld).

¹⁰⁵ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰⁶ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰⁷ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

relationship with their federal partners and engage in dialogue about issues rather than just submitting written comments.¹⁰⁸

The informal nature of communications also drew concern from states, however. In particular, states felt that they did not always hear from the federal government about policy decisions when they felt they should have. For example, one official from a state with a partnership exchange noted that they first learned through the *New York Times* that the federal government was going to delay implementing employee choice (a functionality whereby a single employer can allow their employees to choose from multiple different health plans offered by different insurers) in federally run small business exchanges.¹⁰⁹ The delays resulted, in part, from the rulemaking process itself, as federal staff was barred from answering questions while they were drafting rules.¹¹⁰ At most, states might have learned the gist of a rule a few hours before it was released.¹¹¹ Other times, state officials felt the delays were more strategic: “The press was hungry to point out any flaws. That created some hesitancy on the part of the feds to share things with the states.”¹¹² For example, state officials reported not getting advance notice before the administration announced that it was adopting a transitional policy whereby health insurers could continue to renew policies that do not meet the ACA’s requirements beyond January 1, 2014,¹¹³ and that it would be changing the coverage effective date for plans purchased through the federally facilitated exchange between December 15th and 23rd and that it encouraged state-based exchanges to do the

¹⁰⁸ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹⁰⁹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹¹⁰ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹¹¹ Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld).

¹¹² Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld).

¹¹³ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld). The policy was announced in a public letter to insurance commissioners released on November 14, 2013. Letter from Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ins. Comm’rs (Nov. 14, 2013), *available at* <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf>.

same.¹¹⁴ Many state officials also commented that their primary contacts were not always kept up to date on policy or operational changes.¹¹⁵

State officials also perceived that the federal government was reluctant to put anything in writing due to political pressure, and reported getting different answers to the same questions from one week to the next as different people would join their discussions: “It was hard to get real consistent answers.”¹¹⁶ One state official expressed particular frustration that they were never allowed to speak to the HHS Office of the General Counsel (OGC), describing OGC as a “mysterious entity, like the Wizard of Oz.”¹¹⁷ Messages would be channeled between intermediaries who did not necessarily have legal expertise or an understanding of health insurance, opening the door for miscommunications and misunderstanding.¹¹⁸

¹¹⁴ Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld). This policy was announced in a fact sheet released on December 12, 2013. *Taking Steps to Smooth Consumers' Transition into Health Coverage Through the Marketplace*, CMS.GOV (Dec. 12, 2013), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-12-12.html>. This proposal was published in interim final rule five days later. Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76,212 (Dec. 17, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

¹¹⁵ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹¹⁶ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); *see also, e.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

¹¹⁷ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

¹¹⁸ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld). This frustration particularly arose with respect to questions regarding sub-regulatory guidance, which, unlike rules issued through notice-and-comment rulemaking, are not required to cite the legal authority under which they are being issued. *See* William Funk, *A Primer on Nonlegislative Rules*, 53 ADMIN. L. REV. 1321, 1322 (2001)

2. Indirect Communication

State officials offered differing opinions on the value of using third parties, including members of Congress and the press, to influence federal decision-making. In some cases, state officials implied that going to the press or other third parties would be a breach of the trust and bonds they had with federal officials. According to one official from a state with a federally run exchange, “[o]ur feeling was that we can [sic] take care of our own issues. We had established relationships not only with our project officer but other people within CCIIO If I needed to, I would elevate issues up to [the senior staff level].”¹¹⁹ Another framed it politically, “[o]ur governor wants to support the Obama Administration and exchange implementation. There have been times when we could have gone out of our way to point out problems, and we haven’t done that.”¹²⁰ Others simply rejected the option as unnecessary¹²¹ or expressed concern that it would not benefit them to go to the press.¹²²

States appeared more willing to use their congressional delegation to escalate an issue than the press.¹²³ One official characterized this as a “more muted” option than going public with concerns.¹²⁴ However, this option was only available to the extent state officials perceived their

(“These rules . . . are not ‘law’ in the way that statutes and substantive rules that have gone through notice and comment are ‘law,’ in the sense of creating legal obligations on private parties.”).

¹¹⁹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹²⁰ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²¹ Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²² Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²³ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²⁴ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

congressional delegation to be supportive of their requests, which was not the case in every state.¹²⁵

Among states that were more willing to use third parties, most reported only doing so as a last resort. According to a state-based exchange official, “[i]t’s a stronger option that we only turn to if no movement and it’s not needed very often. But there have been times when they’ve been involved.”¹²⁶ Some states would be willing to pull the trigger more quickly than others, though. As one official from a state with a state partnership exchange reported, “[a]ny time we had a problem, we felt like we could go to [our Senator]. And we did. And we felt we could use the press if we were having trouble If there wasn’t communications [sic] with us, we’d make it known.”¹²⁷

C. THE ROLE OF THE STATE INTEREST GROUPS AND CROSS-STATE COLLABORATION

The NAIC played a particularly active role in exchange implementation. Congress recognized the potential value of NAIC (self-described as, “the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories”¹²⁸) in the ACA. The statute calls on the Secretary of HHS to consult with NAIC on numerous occasions,¹²⁹ including multiple provisions closely to exchange implementation.¹³⁰ HHS has since not merely consulted with NAIC, but in

¹²⁵ Compare Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld) (noting supportive relationship), with Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld) (noting unsupportive relationship).

¹²⁶ Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld).

¹²⁷ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹²⁸ Senator Ben Nelson, *About the NAIC*, NAT’L ASS’N OF INS. COMM’RS, http://www.naic.org/index_about.htm (last visited May 22, 2015).

¹²⁹ See, e.g., Patient Protection and Affordable Care Act §§ 1333(a)(1), 1341(b)(1), 42 U.S.C. §§ 18053(a)(1), 18061(b)(1) (2012).

¹³⁰ See, e.g., Patient Protection and Affordable Care Act §§ 1311(c)(1)(F), 1321(a)(2), 42 U.S.C. §§ 18031(c)(1)(F), 18041(a)(2) (2012).

fact relied on it to write first drafts of key regulations¹³¹ and templates of a uniform summary of benefits and coverage.¹³²

Particularly early on, before it had developed relationships with individual states, the federal government relied on state interest groups to convey messages to and from the states.¹³³ HHS acknowledged this important convening role of state interest groups early on when it sent a letter to the presidents of NAIC, the National Conference of State Legislatures (NCSL), and the National Governors Association (NGA) accompanying its first guidance document on exchanges.¹³⁴ The letter states:

As we look ahead to the establishment of the Exchanges and other reforms, it is essential that we work closely with states every step of the way.

The enclosed guidance is another sign of our commitment to provide states with timely, useful information and assistance in response to the priorities and needs states have communicated to us. It provides transparency in our efforts and offers states interested in acting in the coming year input into the structure and function of Exchanges.¹³⁵

The letter also acknowledges NAIC's work to draft model exchange legislation, adding that the "preliminary drafts currently under review are in

¹³¹ Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 563–64 (2011) (noting that HHS adopted NAIC's draft medical loss ratio regulations).

¹³² Sutherland Asbill & Brennan LLP, *New Rules for Summaries of Health Benefits and Coverage*, LEXOLOGY (Aug. 23, 2011), <http://www.lexology.com/library/detail.aspx?g=55f86fb0-247e-4ff4-87b5-884aba08f4b6>.

¹³³ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹³⁴ Letter from Kathleen Sebelius, Sec'y of Health & Human Servs., to Christine Gregoire, Governor of Wash., Jane L. Cline, President, Nat'l Ass'n of Ins. Comm'rs, and Senator Richard T. Moore (Nov. 18, 2010), *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_guidance_cove_r_letter_101118.pdf (regarding initial guidance on Health Insurance Exchanges).

¹³⁵ *Id.* at 1.

accordance with the statute and will serve as a helpful model for states to establish authorizing legislation for their Exchanges.”¹³⁶

Since then, all three organizations have been active in exchange-related activities. NCSL and NAIC were moderate to frequent participants in notice-and-comment rulemaking,¹³⁷ and NAIC, as well as NGA, has sent public letters to HHS, the White House, and members of Congress outside of commenting periods to emphasize points of concerns.¹³⁸ In addition, the

¹³⁶ *Id.* at 2.

¹³⁷ *See, e.g.*, Letter from Susan E. Voss, Iowa Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Kevin M. McCarty, Fla. Ins. Comm’r & President-Elect, Nat’l Ass’n of Ins. Comm’rs, James J. Donelon, La. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Adam Hamm, N.D. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n. of Ins. Comm’rs, to Donald Berwick, Adm’r, Ctrs. for Medicare & Medicaid Servs. (Oct. 5, 2011), *available at* http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services2.pdf; *see also Special Section: Patient Protection and Affordable Care Act & State Insurance Regulation*, NAT’L ASS’N. OF INS. COMM’RS, http://www.naic.org/index_health_reform_section.htm (last visited May 22, 2015). Additional comment letters include NCSL on the Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (OCIIO-9989-NC); Establishment of Exchanges and Qualified Health Plans Proposed Rule (CMS-9989-P); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 Final and Interim Final Rules (CMS-2349-F); and Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule (CMS-9980-P). Letters are available by searching the respective file code (in parentheses) on nctl.org.

¹³⁸ *See, e.g.*, Letter from Terry Branstad, Governor of Iowa & Chair, Health & Human Servs. Comm., Nat’l Governors Ass’n, and Pat Quinn, Governor of Ill. & Vice Chair, Health & Human Servs. Comm., Nat’l Governors Ass’n, on behalf of the Nat’l Governors Ass’n, to Kathleen Sebelius, Sec’y, Dep’t of Health & Human Servs. (Nov. 2, 2011), *available at* <http://www.nga.org/cms/home/federal-relations/nga-letters/health--human-services-committee/col2-content/main-content-list/november-2-2011-letter---health.html>; Letter from Susan E. Voss, Iowa Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Kevin M. McCarty, Fla. Ins. Comm’r & President-Elect, Nat’l Ass’n of Ins. Comm’rs, James J. Donelon, La. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Adam Hamm, N.D. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to Kathleen Sebelius, Sec’y, Dep’t of Health & Human Servs. (Nov. 7, 2011), *available at* http://www.naic.org/documents/index_health_reform_111107_naic_letter_sec_sebeilus_exchange_partner_guide.pdf;

groups have convened numerous in-person meetings and calls where states can meet with each other and with federal officials. For example, in 2011, NGA hosted a two-day meeting entitled, “Timelines, State Options, and Federal Regulations,” that was attended by more than 120 state officials and ended with a group meeting with federal officials from HHS and the Department of Treasury on exchange implementation.¹³⁹ A year later, NGA again convened a two-day meeting at which participants compiled a lengthy list of questions for federal officials on exchanges and Medicaid

Letter from James J. Donelon, La. Ins. Comm’r & President, Nat’n Ass’n of Ins. Comm’rs, Adam Hamm, N.D. Ins. Comm’r & President-Elect, Nat’l Ass’n of Ins. Comm’rs, Monica J. Lindeen, Mont. Comm’r of Sec. & Ins. & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Michael F. Consedine, Pa. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to John Boehner, Speaker, U.S. House of Representatives, Harry Reid, Majority Leader, U.S. Senate, Nancy Pelosi, Minority Leader, U.S. House of Representatives, and Mitch McConnell, Minority Leader, U.S. Senate, (Nov. 6, 2013), *available at* http://www.naic.org/documents/index_health_reform_comments_131106_naic_letter_to_congress_aca_implementation.pdf; Letter from Adam Hamm, N.D. Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Monica J. Lindeen, Mont. Comm’r of Sec. & Ins. & President-Elect, Nat’n Ass’n of Ins. Comm’rs, Michael F. Consedine, Pa. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Sharon P. Clark, Ky. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to Dr. Mandy Cohen, Interim Dir., Ctr. for Consumer Info. & Ins. Oversight (Apr. 23, 2014), *available at* http://www.naic.org/documents/index_health_reform_comments_140423_naic_letter_cciio_network_adequacy.pdf; Letter from Adam Hamm, N.D. Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Monica J. Lindeen, Mont. Comm’r of Sec. & Ins. & President-Elect, Nat’n Ass’n of Ins. Comm’rs, Michael F. Consedine, Pa. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, Sharon P. Clark, Ky. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, and Senator E. Benjamin Nelson, Chief Exec. Officer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to President Barack Obama (Apr. 30, 2014), *available at* http://www.naic.org/documents/index_health_reform_comments_140501_naic_letter_wh_followup_letter.pdf.

¹³⁹ KRISTA DROBAC, NGA CENTER FOR BEST PRACTICES ISSUE BRIEF: STATE PERSPECTIVES ON INSURANCE EXCHANGES: IMPLEMENTING HEALTH REFORM IN AN UNCERTAIN ENVIRONMENT (Sept. 16, 2011), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/1109NGAEXCHANGESSUMMARY.PDF>.

expansion.¹⁴⁰ Federal officials also regularly attend NAIC's bi-annual conferences.¹⁴¹

All three organizations have also published materials to assist states. NAIC's efforts are particularly noteworthy and include a model law on exchange establishment,¹⁴² a chart of federal ACA FAQs,¹⁴³ summaries of clear or potential preemptions on state authority with respect to qualified health plans and health plans sold outside exchanges,¹⁴⁴ a summary of decisions to be made by states with a federally run exchange,¹⁴⁵ and white papers on topics including accreditation and quality,¹⁴⁶ marketing and

¹⁴⁰ NAT'L GOVERNORS ASS'N, HEALTH CARE: DECISION POINTS FOR STATES MEETING SUMMARY (July 26, 2012), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/HealthCareDecisionPointsforStates.pdf>. An appendix with the full list of questions from states is available at <http://www.nga.org/files/live/sites/NGA/files/pdf/AppendixQuestionsfromStates.pdf>.

¹⁴¹ *See, e.g., Health Insurance Exchanges Focus of Governors Session*, NAT'L GOVERNORS ASS'N (July 16, 2011), http://www.nga.org/cms/home/news-room/news-releases/page_2011/col2-content/main-content-list/health-insurance-exchanges-focus.html; Nat'l Ass'n of Ins. Comm'rs, 2014 NAIC Spring National Meeting Final Registration List; Nat'l Ass'n of Ins. Comm'rs, 2013 NAIC Fall National Meeting Final Registration List.

¹⁴² AM. HEALTH BENEFIT EXCH. MODEL ACT (2010), *available at* http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

¹⁴³ NAT'L ASS'N OF INS. COMM'RS, ALL ACA-RELATED FEDERAL FAQs AS OF OCTOBER 9, 2013, *available at* http://www.naic.org/documents/index_health_reform_faq.pdf.

¹⁴⁴ NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: QUALIFIED HEALTH PLANS (June 27, 2013), *available at* http://www.naic.org/documents/committees_b_130627_preemption_analysis_qhp.pdf; NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: HEALTH PLANS OUTSIDE EXCHANGES (June 27, 2013), *available at* http://www.naic.org/documents/committees_b_130627_preemption_analysis_outside_market.pdf.

¹⁴⁵ NAT'L ASS'N OF INS. COMM'RS, STATE DECISIONS: FEDERALLY FACILITATED EXCHANGE (FFE) STATES (June 27, 2013), *available at* http://www.naic.org/documents/committees_b_130627_ffestate_decisions.pdf.

¹⁴⁶ NAT'L ASS'N OF INS. COMM'RS, EXCHANGES PLAN MANAGEMENT FUNCTION: ACCREDITATION AND QUALITY WHITE PAPER (2012), *available at* http://www.naic.org/documents/committees_b_related_wp_accred_quality.pdf.

consumer assistance,¹⁴⁷ and network adequacy.¹⁴⁸ In addition, NCSL has maintained up-to-date resources on state action on exchanges¹⁴⁹ and NGA has published issue briefs on exchange implementation.¹⁵⁰ State officials expressed particular gratitude for their help interpreting the sea of regulations and guidance coming out of the federal government.¹⁵¹

More recently, a fourth state interest group comprised specifically of state exchange directors and staff has formed. The State Health Exchange Leadership Network, also known informally as “Exchangers,” is convened by the National Academy of State Health Policy (NASHP).¹⁵² It is led by an eleven-person steering committee of state and exchange officials representing all exchange models,¹⁵³ and currently has over 400 members representing all fifty states and the District of Columbia.¹⁵⁴

¹⁴⁷ NAT’L ASS’N OF INS. COMM’RS, MARKETING AND CONSUMER INFORMATION WHITE PAPER: NAVIGATORS, AGENTS AND BROKERS, MARKETING AND SUMMARY OF BENEFITS AND COVERAGE (2012), *available at* http://www.naic.org/documents/committees_b_related_wp_marketing_consumer_info.pdf.

¹⁴⁸ NAT’L ASS’N OF INS. COMM’RS, PLAN MANAGEMENT FUNCTION: NETWORK ADEQUACY WHITE PAPER (2012), *available at* http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

¹⁴⁹ Richard Cauchi, *State Actions to Address Health Insurance Exchanges*, NAT’L CONFERENCE OF STATE LEGISLATURES (May 1, 2015), <http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx>.

¹⁵⁰ *See, e.g.*, TOM DEHNER, NGA CENTER FOR BEST PRACTICES ISSUE BRIEF: STATE HEALTH INSURANCE EXCHANGES AND CHILDREN’S COVERAGE: ISSUES FOR STATE DESIGN DECISIONS (Aug. 29, 2011), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/1108CHILDRENHEALTHEXCHANGES.PDF>.

¹⁵¹ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

¹⁵² NAT’L ACAD. FOR STATE HEALTH POL’Y, STATE HEALTH EXCHANGE LEADERSHIP NETWORK: 2013 ANNUAL REPORT 3 (2014), http://nashp.org/sites/default/files/Exchangers_Annual_Report_FINAL.pdf.

¹⁵³ As of April 2014, Steering Committee Members represented the following states: Arizona, Colorado, Connecticut, Idaho, Illinois, Kansas, Kentucky, New Mexico, Oregon, Washington, and West Virginia. Nat’l Acad. for State Health Pol’y, State Health Exchange Leadership Network: Steering Committee Membership (Apr. 2014), *available at* http://www.nashp.org/sites/default/files/Steering_Committee_membership_list_4-2014.pdf.

¹⁵⁴ NAT’L ACAD. FOR STATE HEALTH POL’Y, *supra* note 152, at 4–5.

Unlike NAIC, NCSL, and NGA, the “Exchangers” is not formed as an association and does not conduct official lobbying itself.¹⁵⁵ It does, however, facilitate regular calls between state exchange directors and staff and online information sharing between states,¹⁵⁶ and is currently building relationships with federal officials.¹⁵⁷ One state official noted that this group filled an important gap, as much of exchange implementation, such as building call centers and eligibility systems, fell beyond the scope of the existing groups’ expertise.¹⁵⁸

Outside of these formal networks, collaboration between states in terms of advocating the federal government appears to have been irregular (information sharing, in contrast, was much more common). On only three instances did states come together to submit multi-state comment letters in response to formal notice-and-comment rulemaking independent of the NAIC, NGA, or NCSL,¹⁵⁹ and, in interviews, state officials often reported that they did not typically band together for lobbying purposes. There were some exceptions, however. For example, an official from a state with a partnership exchange noted that they coordinated with other states to successfully discourage CCIIO from requiring partnership states from entering into formal memoranda of understanding (MOUs).¹⁶⁰ In addition, officials reported that a handful of states defaulting to federally run

¹⁵⁵ Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld).

¹⁵⁶ NAT’L ACAD. FOR STATE HEALTH POL’Y, *supra* note 152, at 4.

¹⁵⁷ Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld).

¹⁵⁸ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹⁵⁹ Pam Bondi, Fla. Attorney Gen., et al., Comments from the States of Florida, Alabama, Georgia, Kansas, Michigan, Nebraska, North Dakota, South Carolina, Texas, and West Virginia on Consumer Protection Issues Raised by HHS’s Proposed Rule (CMS-9949-P) (Apr. 21, 2014), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2014-0036-0163> (including comments on consumer protection issues raised by HHS’s proposed rule); Caroline M. Brown & Philip J. Peisch, Joint Comments on Behalf of Nine States and State Agencies Regarding Proposed Rules for Alternative Benefit Plans (Feb. 21, 2013), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0453>; Gordon, *supra* note 92 (reprinting a letter to federal officials from officials from Arizona, Tennessee, and Utah).

¹⁶⁰ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

exchanges joined forces to ensure they could maintain authority over the regulation of qualified health plans. Their collective advocacy ultimately resulted in the creation of the “marketplace plan management option” by which states could conduct plan management on behalf of the federally run exchange, which seven states—Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia—ultimately took part in for 2014.¹⁶¹ According to one participant in the group: “It worked out really well for us. At some point HHS acknowledged that there was this core group of states [that wanted to be engaged in exchange implementation] and started reaching out to us collectively.”¹⁶²

IV. FACTORS AFFECTING STATE INFLUENCE OVER FEDERAL DECISION-MAKING

Objectively assessing how much influence state officials ultimately had over exchange implementation is difficult.¹⁶³ Rather than attempt to tally victories and losses and speculate over whether a state’s input, versus other factors, drove any given decision, this Part more broadly identifies four factors that appear to have affected how much influence states were able to hold over federal decision-making. These factors include the extent to which the federal government perceived states to share their goals for ACA implementation, limits on federal resources and capacity for exchange implementation, institutional characteristics of the different federal agencies involved and their relevant sub-components, and the ability of states to take “first-mover” advantage.

Prior to proceeding, however, it is worth noting that while the federal government appeared to put more effort into conducting federalism impact analyses than research has found it to in the past, it appears to be a largely pro forma practice. It seems unlikely that the inclusion of federalism impact statements served any public notice function as states were closely monitoring the rulemaking process and were aware that the rules, whether acknowledged by the federal government or not, would

¹⁶¹ DASH ET AL., IMPLEMENTING THE AFFORDABLE CARE ACT, *supra* note 1, at 3.

¹⁶² Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁶³ Seifter, *supra* note 11, at 473–74 (“Empirical studies [of state influence over federal agency decision-making] are scarce, and measuring regulatory influence in any context is notoriously difficult.” (footnote omitted)).

directly impact their interests. In fact, rather than rely on the federal government's federalism analysis, states turned to the NAIC to conduct a comprehensive preemption review.¹⁶⁴ In addition, while it is possible that federal officials were inspired to conduct additional outreach to states and/or revise their decisions in light of Executive Order 13,132, there was no suggestion that this was in fact the case. Any increase in attentiveness to state interests may be just as readily explained by the previously mentioned command in the ACA that the Secretary of HHS consults with state insurance regulators.¹⁶⁵

A. STATE INTERESTS AND THE COMPETING GOALS OF THE ACA

The ACA embodies multiple and sometimes competing goals. Broadly speaking, one of its primary purposes is to reduce the number of people who are uninsured by promoting access to more affordable coverage through Medicaid expansion, financial support for low-to-moderate income families purchasing private coverage, and reforming the private health insurance market so companies can no longer deny coverage to those who need it.¹⁶⁶ The law is also intended to strengthen consumer rights and protections for people who are already or become insured.¹⁶⁷ At the same time, Congress specifically rejected a national model for exchange implementation in favor of the state-led approach.¹⁶⁸ Thus, while the

¹⁶⁴ NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: HEALTH PLANS OUTSIDE EXCHANGES, *supra* note 144; NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: QUALIFIED HEALTH PLANS, *supra* note 144.

¹⁶⁵ Patient Protection and Affordable Care Act § 1321(a), 42 U.S.C. § 18041(a) (2012) (establishment of standards for state flexibility in operation and enforcement of exchanges and related requirements).

¹⁶⁶ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2612–14, 2629 (2012) (Ginsburg, J., dissenting).

¹⁶⁷ *Id.* at 2626 (2012) (Ginsburg, J., dissenting) (“Recall that one of Congress' goals in enacting the Affordable Care Act was to eliminate the insurance industry's practice of charging higher prices or denying coverage to individuals with preexisting medical conditions.”).

¹⁶⁸ Gluck, *supra* note 7, at 1757 (“[E]xchange governance was the key question that divided the House and Senate versions of the legislation, with the Senate invoking ‘federalism’ values to insist on the state-leadership default preference that ultimately carried the day.”); *see also* Metzger, *supra* note 7, at 576 (“This reliance on state-run exchanges marks a significant difference between the

federal government was asserting new control over an area traditionally regulated by the states by setting broad consumer protection rules, it continued to value at least some state flexibility.¹⁶⁹ As Professor Gillian Metzger has commented in light of similar approaches by the Obama Administration in other areas of the law, this represents “federalism in service of progressive policy, not a general devolution of power and resources to the states.”¹⁷⁰

Indeed, some academics have characterized HHS’s approach to implementation as reflecting a “general policy of flexibility toward states’ efforts to carry out their obligations under the ACA,”¹⁷¹ or, more strongly, a “policy of ‘maximum flexibility’ to the states on a number of the key implementation points involving the health exchanges and other variables.”¹⁷² And, in interviews, officials widely acknowledged that the federal government has provided states significant independence in most areas.¹⁷³ However, there appears to be a limit to this flexibility if the federal government perceives that state flexibility or accommodation may be

Senate bill that became the ACA and the earlier House version. The latter had assigned primary responsibility for operating a national uniform exchange to the federal government, with states allowed to opt in to operate state-based exchanges if they met federal requirements. State officials lobbied strongly for state-based exchanges and for states to retain broad regulatory authority over insurance.” (footnotes omitted).

¹⁶⁹ Gluck, *supra* note 131, at 579. (“[T]he ACA’s text itself mentions ‘state flexibility’ six times in the context of the exchange provisions.”).

¹⁷⁰ Metzger, *supra* note 7, at 569–70.

¹⁷¹ Bagenstos, *supra* note 41, at 230.

¹⁷² Theodore W. Ruger, *Health Policy Devolution and the Institutional Hydraulics of the Affordable Care Act*, in *THE HEALTH CARE CASE: THE SUPREME COURT’S DECISION AND ITS IMPLICATIONS* 359, 362 (Nathaniel Persily, Gillian E. Metzger & Trevor W. Morrison eds., 2013).

¹⁷³ See, e.g., Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state interest group (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

perceived to threaten the ACA's primary goal of coverage expansion. As a former federal official described:

If you look at the regulation we put out in July 2011 [on exchange establishment]—which was mostly about plan management and consumer outreach functions of the exchange—the watchwords were state flexibility. We almost needed synonyms for flexibility because we used it too much. . . . But when the next regulation came out in August—on eligibility and enrollment—the watchwords were seamless consumer experience and not state flexibility. If anything, it was supposed to be totally regimented. Determinations should come out exactly the same for consumers answering questions in different states. . . . We didn't want states innovating around determining if someone is eligible for a tax credit or not.¹⁷⁴

A striking example of this comes from Utah's negotiations with the federal government over which exchange model to pursue. In December 2012, Utah Governor Gary Herbert submitted a declaration letter indicating interest in pursuing a state-based exchange.¹⁷⁵ However, he noted that his willingness to move forward was contingent on having “flexibility to stay true to Utah principles.”¹⁷⁶ Around this time, the Utah small business exchange was frequently compared to Massachusetts' exchange.¹⁷⁷ These comparisons primarily focused on the two exchanges' differing approaches to plan management: Utah had adopted a take all comers approach to insurer participation, while Massachusetts established more stringent

¹⁷⁴ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

¹⁷⁵ Letter from Gary R. Herbert, Governor of Utah, to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Dec. 14, 2012), *available at* <http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ut-declaration-letter.pdf>.

¹⁷⁶ *Id.*

¹⁷⁷ *See, e.g.,* SABRINA CORLETTE ET AL., GEO. U. HEALTH POL'Y INST., THE MASSACHUSETTS AND UTAH HEALTH INSURANCE EXCHANGES: LESSONS LEARNED (Geo. Univ. Health Pol'y Inst. Ctr. for Children & Families ed., 2011), *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/03/Health-reform_exchanges.pdf.

standards for which insurers could participate and what they could offer.¹⁷⁸ This, however, was not an issue as the federal exchange rules gave states significant leeway in this area,¹⁷⁹ and, in fact, the federal government opted to pursue an approach that looked more like the Utah model than the Massachusetts model for federally run exchanges.¹⁸⁰ Instead, the sticking point was over whether Utah would administer Medicaid eligibility determinations or assessments or offer premium tax credits through the exchange. In a speech to the American Enterprise Institute in February 2012, Governor Herbert stated:

We want to maintain clear separation between private insurance options in our market based exchange and the welfare based public programs such as Medicaid. In order to preserve the market-based principles behind Utah's unique exchange, it is critical that the exchange remain focused on the core mission of creating competition and choice in insurance markets. Those who are in need

¹⁷⁸ See, e.g., Sharon Silow-Carroll et al., *Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection*, STATES IN ACTION: INNOVATIONS IN STATE HEALTH POL'Y (Commonwealth Fund, New York, N.Y.), Mar. 17, 2011, available at <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Feature/Feature.aspx>.

¹⁷⁹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,406 (Mar. 27, 2012) ("As we noted in the preamble to the Exchange establishment proposed rule, we believe that an Exchange's certification approach may vary based upon market conditions and the needs of consumers in the service area. Accordingly, in this final rule, we offer flexibility to Exchanges on several elements of the certification process, including the contracting model, so that Exchanges can appropriately adjust to local market conditions and consumer needs. An Exchange could adopt its contracting approach from a variety of contracting strategies, including an any qualified plan approach, a selective contracting model based on predetermined criteria, or direct negotiation with all or a subset of QHPs.").

¹⁸⁰ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES, *supra* note 61 ("To ensure a robust QHP market in each State where an FFE operates, and to promote consumer choice among QHPs, at least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards.").

should have the opportunity to get assistance, but that determination and effort should be done separately.¹⁸¹

The federal government would not accommodate Utah's requests. However, HHS revised its regulations to create a middle ground, allowing Utah to continue to operate its small business exchange while the federal government stepped in to run the individual market exchange.¹⁸²

More generally, a state official from a state-based exchange state acknowledged that they were given flexibility "so long as what we are doing contributes to the goal of getting as many people enrolled as possible, with as few gaps as possible If we were trying to go the other direction, we would have seen more pushback."¹⁸³ Officials from states with partnership exchanges reported sometimes being constrained even though they shared the same goals with the federal government, because the flexibility or authority that would apply to them would also apply to states that strongly opposed implementation of health insurance exchanges.¹⁸⁴

It is important to note that there was not always a clear line between states that shared the administration's goals and those that did not. At least some state officials from states defaulting to federally run exchanges went out of their way to work with the federal government to ensure that implementation went smoothly. In some cases, this reflects divisions within states over the ACA. One official commented, "[b]ecause I do show up at face-to-face meetings and to talk [to federal officials] personally, and because the [state insurance] commissioner is trying to support health reform, when I call them or send them an email or tell them there is a problem with something, it usually gets responded to."¹⁸⁵ Yet,

¹⁸¹ Gov. Gary R. Herbert, Remarks at American Enterprise Institute, Utah's Vision for Healthcare Reform (Feb. 6, 2013), *available at* <http://www.utah.gov/governor/docs/Speech-HealthcareSpeechToAmericanEnterpriseInstitute.pdf>.

¹⁸² Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule, 78 Fed. Reg. 54,070, 54,075-76 (Aug. 30, 2013) (to be codified at 45 C.F.R. §§ 155.100, 155.105, 155.140).

¹⁸³ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹⁸⁴ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹⁸⁵ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

another state official found that even though their boss personally disagreed with certain things, they were willing to make things work.¹⁸⁶

B. FEDERAL FINANCIAL RESOURCES AND CAPACITY

Limitations on federal resources and capacity appeared to play a meaningful role in determining if and when the federal government would accommodate state preferences. In interviews, both state and former federal officials noted that the federal government did not anticipate that so many states would opt out of running their own exchanges.¹⁸⁷ One state official added that “once there got to be so many [states opting out], federal officials were at the mercy of being much more flexible and were willing to give as much as they could to any state participating having a dialogue with them.”¹⁸⁸ Particularly pressing was the difference in financial resources available to states versus the federal government. While states can continue to apply for an unlimited amount of section 1311 establishment funds through the end of 2014,¹⁸⁹ the ACA dedicated no funds to federal exchange operations. Instead, it only appropriated \$1 billion to HHS for federal administrative expenses related to implementing the ACA writ large.¹⁹⁰ HHS has been forced to scrape together resources from existing appropriations funds, including HHS’s General Departmental Management

¹⁸⁶ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹⁸⁷ *E.g.*, Interview with senior official, state with state-run health insurance exchange (March 18, 2014) (interview identity and affiliation withheld); Interview with former senior federal official (March 24, 2014) (interviewee identity and affiliation withheld).

¹⁸⁸ Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld).

¹⁸⁹ Patient Protection and Affordable Care Act § 1311(a), 42 U.S.C. §18031(a) (2012) (providing assistance to states to establish American Health Benefit Exchanges).

¹⁹⁰ Health Care and Education Reconciliation Act of 2010 § 1005, 42 U.S.C. § 18121 (2012) (“(a) IN GENERAL. There is hereby established a Health Insurance Reform Implementation Fund (referred to in this section as the “Fund”) within the Department of Health and Human Services to carry out the Patient Protection and Affordable Care Act and this Act (and the amendments made by such Acts). (b) FUNDING. There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, \$1,000,000,000 for Federal administrative expenses to carry out such Act (and the amendments made by such Acts).”).

Account, CMS's Program Management Account, the Prevention and Public Health Fund, and HHS's Nonrecurring Expenses Fund, to support its activities.¹⁹¹ In contrast, as of January 2014, more than \$4.6 billion in federal grant dollars has been awarded to states (with nearly one quarter of state grant dollars going to California).¹⁹²

The most obvious development coming out of this dynamic has been the introduction of novel exchange models. The idea of a hybrid "partnership" model where functionalities would be shared between a state and the federal government was first introduced publicly in the July 2011 proposed rule on exchange establishment in response to state pressure for more options.¹⁹³ Many states, however, bridled at the "partnership" label

¹⁹¹ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-601, STATUS OF CMS EFFORTS TO ESTABLISH FEDERALLY FACILITATED HEALTH INSURANCE EXCHANGES 1, 12 (2013), *available at* <http://www.gao.gov/assets/660/655291.pdf>.

¹⁹² *Total Health Insurance Exchange Grants*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/total-exchange-grants/> (last visited May 22, 2015).

¹⁹³ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,870 (proposed July 15, 2011) ("HHS has pursued various forms of collaboration with the States to facilitate, streamline and simplify the establishment of an Exchange in every State. These efforts have made it clear that for a variety of reasons including reducing redundancy, promoting efficiency, and addressing the tight implementation timelines authorized under the Affordable Care Act, States may find it advantageous to draw on a combination of their own work plus business services developed by other States and the Federal government as they move toward certification. Some States have expressed a preference for a flexible State partnership model combining State-designed and operated business functions with Federally designed and operated business functions. Examples of such shared business functions might include eligibility and enrollment, financial management, and health plan management systems and services. We note that States have the option to operate an exclusively State-based Exchange. HHS is exploring different partnership models that would meet the needs of States and Exchanges."). Over time, the federal government elaborated on how responsibilities and authority would be divided: while legally, state partnership exchanges would be federally facilitated exchanges, states entering into partnerships could conduct plan management responsibilities and/or certain consumer assistance functions, including operating an in-person assistance program funded by § 1311 exchange establishment grants to supplement the statutorily mandated navigator program, which could not be supported by such funds. Letter from Ctr. for Consumer Info. & Ins. Oversight, Affordable Insurance Exchanges Guidance: Guidance on the State Partnership Exchange (Jan. 3, 2013), *available at* <http://www.cms.gov/>

and the formal application process the federal government required states to follow to enter into a partnership.¹⁹⁴ In February 2013, the Kansas Insurance Commissioner sent a letter to the director of CCIIO explaining that while there was “no political support for a partnership arrangement,” the state would like approval to perform plan management functions (such as certifying that health plans met state and federal statutory and regulatory requirements) on behalf of the federally run exchange.¹⁹⁵ Five days later, CCIIO issued a FAQ allowing for states to conduct plan management so long as they submitted a letter from their governor or insurance commissioner attesting to their legal authority and operational capacity to do so and agreed to participate in a one-day review session with the federal government.¹⁹⁶

Over time, the federal government also expanded the scope of activities for which states could use exchange establishment and planning grants. For example, in June 2012, guidance generally provided that states with federally facilitated exchanges could use funds to support a transition to a state-based or state partnership exchange or to cover the costs of state activities to establish interfaces with the federal exchange.¹⁹⁷ Ten months later, the federal government clarified that states with federally run exchanges could use section 1311 funds to conduct statewide marketing

CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf.

¹⁹⁴ According to one state official, state insurance regulators stressed to HHS that they “cannot use the word partnership. That would immediately turn off our governor’s offices.” Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁹⁵ Letter from Sandy Praeger, Comm’r of Ins., Kan. Ins. Dept., to Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, Re: Proposal to Perform Plan Management Functions for Federally Facilitated Exchange (Feb. 15, 2013), available at <http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ks-exchange-letter-2-15-2013.pdf>.

¹⁹⁶ Letter from Ctr. for Consumer Info. & Ins. Oversight, Frequently Asked Questions: State Evaluation of Plan Management Activities of Health Plans and Issuers (Feb. 20, 2013), available at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/plan-management-faq-2-20-2013.pdf>.

¹⁹⁷ Ctr. for Consumer Info. & Ins. Oversight, *Exchange Establishment Cooperative Agreement Funding FAQs*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-est-grant-faq-06292012.html> (last visited May 22, 2015).

activities to promote the exchange.¹⁹⁸ More guidance was provided just a few weeks after that, allowing federally run exchange states to use section 1311 funds for activities including, among other things, participating in stakeholder consultations with HHS; compiling and sharing with HHS information on state licensure requirements for navigators, agents, and brokers; gathering and sharing state-specific content for the federal web portal; and conducting other policy analysis and research to support exchange operations.¹⁹⁹ Similarly, an official from a state with a partnership exchange noted that they had originally been told they would need to rely on the federal call center, but later they and other states were able to get approval to operate their own,²⁰⁰ thus expanding state responsibilities to take pressure off the federal government.

Resource limitations at the federal level did not always lend itself towards increased flexibility for states, however. To the extent certain functions stayed within the federal government, limited resources and capacity necessitated greater uniformity—a “one-size-fits-all” model.²⁰¹ As one state official noted, “CMS was supposed to head implementation in the states, but became the implementation body for the nation It’s hard working with three or four different states, let alone thirty-six with different interests.”²⁰² Another informant felt that the federal government had the “attitude that if they were running the exchange for states, the states would

¹⁹⁸ Ctr. for Consumer Info. & Ins. Oversight, *Using Section 1311(a) Funding for Marketing Activities in a Plan Management State Partnership Marketplace or Federally-facilitated Marketplace FAQs*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketplace-funding-marketing-faq.html> (last visited May 22, 2015).

¹⁹⁹ Ctr. for Consumer Info. & Ins. Oversight, *Frequently Asked Questions on Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html> (last visited May 22, 2015).

²⁰⁰ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²⁰¹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²⁰² Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld).

need to take it. CCIIO didn't have the resources or staff" to provide for a lot of variation across states.²⁰³

C. INSTITUTIONAL CHARACTERISTICS WITHIN AND ACROSS
FEDERAL AGENCIES

A nearly universal theme in interviews with state officials was immense respect for and appreciation of CCIIO's willingness to work with states and be flexible. Multiple informants commented that working with CCIIO was the best experience they ever had interacting with the federal government.²⁰⁴ CCIIO staff would go out of their way to work with the states and were always available, including returning calls while they were technically on vacation.²⁰⁵ One state official compared their experience implementing exchanges to Medicare Advantage:

The experience between this and Medicare Advantage has just been night and day. Back in 2006, we were having phone calls with CMS at that point where both of us were threatening lawsuits on a daily basis. To actually have as much dialogue as we have had and as often as we have

²⁰³ Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld).

²⁰⁴ *E.g.*, Interview with senior official, state with state-run health insurance exchange (March 7, 2014) (interviewee identity and affiliation withheld) ("I've worked with several federal agencies And working with CCIIO was unlike working with any other federal agency – [demonstrating] flexibility and interest in making us successful and collaborating with us.") Interview with senior official, federally run health insurance exchange state (March 20, 2014) (interviewee identity and affiliation withheld) ("Of the federal regulators we dealt with throughout this process, CCIIO ultimately became our best partner."); Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld) ("There has been a genuine effort to have a supportive partnership, probably more so than I have ever seen in my bazillion years working with the states and the feds.").

²⁰⁵ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

had. . . . They would take input, and if they didn't take it they'd tell us why. For all of us to work together and not have it break down has been truly remarkable. And we're under so much more political pressure now than in 2006. That makes it very impressive.²⁰⁶

In particular, many informants highlighted the fact that HHS brought in many former state regulators to run CCIIO.²⁰⁷ And, as others have previously noted, former Secretary of HHS Kathleen Sebelius herself is a former state governor and insurance commissioner.²⁰⁸

Some officials noted that part of CCIIO's flexibility also came from the fact that it was a new entity, learning new things.²⁰⁹ One advised, "[I]f you want to get something done you create new state agency or a new federal agencies [sic] and make sure they get support from outlying agencies. If something is just a tweak to system, you can stick it into old agency."²¹⁰ Many state officials felt that CCIIO embodied a very different culture than older federal programs that are more entrenched.²¹¹ CCIIO staff members were relatively young, and respected the judgment of seasoned state regulators²¹² and brought an upstart, "entrepreneurial spirit"

²⁰⁶ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²⁰⁷ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

²⁰⁸ *See, e.g.*, Metzger, *supra* note 7, at 613; Sandy Praeger, *A View from the Insurance Commissioner on Health Care Reform*, 20-SPG KAN. J.L. & PUB. POL'Y 186, 192 (2011); Seifter, *supra* note 11, at 475.

²⁰⁹ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²¹⁰ Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld).

²¹¹ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²¹² Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

to implementation.²¹³ Some state officials expressed frustration with the inexperience of some of the staff they were working with,²¹⁴ but states found that CCIIO staff were always been a willingness to “dig in” and try to get the job done.²¹⁵

Some, but not all, state officials found working with other federal entities, particularly IRS, to be more difficult than working with CCIIO: “CCIIO is very flexible They certainly bent over backwards to work with us. But IRS didn’t. They said here are the rules and we don’t care.”²¹⁶ As another official put it, “IRS doesn’t play well with other kids in the sandbox.”²¹⁷ A former federal official attributed it to IRS’s culture and the nature of their work: “IRS generally sees things in black and white. They very seldom regard an issue as open-ended in a statute If you are doing the tax stuff, you can’t have adaptability. You need consistency and bright lines Nobody asks, “what do we want to achieve?”²¹⁸

Reviews of federal Medicaid officials were mixed. State officials reported that while they were more flexible than IRS, they were also more bureaucratic, with a history and tradition that contributed to seeing states more as followers than partners.²¹⁹ One state official indicated that match funding under Medicaid contributed to this: the Center for Medicaid and CHIP Services (CMCS) “has much more leverage over state Medicaid officials than CCIIO does over state regulators. The conversation is completely different. Getting answers is difficult. The questions are much

²¹³ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²¹⁴ Interview with senior official, state with state-run health insurance exchange (May 2, 2014) (interviewee identity and affiliation withheld) (“What has bothered me immensely is that we have these very inexperienced people, pack of regulators on the federal side, looking at these rules and writing up regulations.”).

²¹⁵ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²¹⁶ Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld).

²¹⁷ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²¹⁸ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

²¹⁹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

terser from federal officials.”²²⁰ In contrast, CCIIO “didn’t seem to be as guarded or use their leverage like other entities.”²²¹

D. FIRST-MOVER ADVANTAGE

In some instances states were able to secure accommodations when they were out ahead of the federal government and able to take a first-mover advantage. In these cases, the federal government appeared hesitant to disrupt functioning markets or to force states to change directions.

The clearest examples come from Massachusetts and Utah, which had moved ahead on establishing exchanges before passage of the ACA. Massachusetts’s health care reform initiative served as a model for the ACA, but the state faced barriers to full compliance due to differences in specific standards. For example, Massachusetts had distinct individual and employer coverage requirements and penalties, more generous subsidies for low-to-moderate income families, and more protective age and tobacco rating rules.²²² Massachusetts had also merged its individual and small group market. While the ACA explicitly did not preempt market mergers, Massachusetts found that implementation of the ACA’s rating reforms would threaten its ability to maintain a merged market.²²³ In response to Massachusetts’ concerns, CCIIO provided Massachusetts with a three-year transition period to phase out certain rating factors that are otherwise prohibited under the ACA.²²⁴ CCIIO cited its authority to section 1321(e) of the ACA, which allows the Secretary “to presume” that certain states

²²⁰ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²²¹ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²²² ROBERT W. SEIFERT & ANDREW P. COHEN, CTR. FOR HEALTH LAW & ECON., UNIV. OF MASS. MED. SCH., RE-FORMING REFORM: WHAT THE PATIENT PROTECTION AND AFFORDABLE CARE ACT MEANS FOR MASSACHUSETTS 7, 9, *available at* <http://bluecrossfoundation.org/sites/default/files/062110NHRReportFINAL.pdf>.

²²³ Letter from Joseph G. Murphy to author (Mar. 29, 2013) (on file with author) (Regarding patient protection and Affordable Care Act; Health insurance market rules; Rate review).

²²⁴ Letter from Gary Cohen, Deputy Adm’r & Dir., Ctr. for Consumer Infor. & Ins. Oversight, to Joseph Murphy, Mass. Comm’r of Ins. (Apr. 5, 2013), *available at* <http://www.mcguirewoods.com/news-resources/publications/mwc/CMS-MA-ACA-waiver.pdf>.

that operated an exchange before January 1, 2010 meet the ACA's approval standards for establishment of a state-based exchange.²²⁵ This arguable stretch of the statute, questioned in the media,²²⁶ demonstrates the great lengths the federal government was willing to go, in certain circumstances, to accommodate early moving states.

Utah had also already established a health insurance exchange for small businesses based on legislation that was enacted before passage of the ACA.²²⁷ Even though Utah refused to operate an ACA-compliant individual market exchange, the federal government ultimately decided to change its rules to allow Utah to continue operating its own small business exchange (Avenue H) while defaulting to a federally run individual market exchange, rather than attempt to compete with or preempt Avenue H by coming in with a federally run exchange serving both markets.²²⁸

As an additional example, a state official recounted that when the federal government first started talking about conducting plan management in states with federally facilitated exchanges, they were planning to build a new IT system.²²⁹ But most states are already on the System for Electronic Rate and Form Filing (SERFF) to facilitate the submission, review, and

²²⁵ Patient Protection and Affordable Care Act § 1321(e), 42 U.S.C. § 18041(e) (2012), (“PRESUMPTION FOR CERTAIN STATE—OPERATED EXCHANGES.—(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.”).

²²⁶ See, e.g., Josh Archambault, *ACA's Alice in Wonderland Twist: HHS Unilateral Delay of Regs for One State*, FORBES, (Apr. 17, 2013), <http://www.forbes.com/sites/theapothecary/2013/04/17/acas-alice-in-wonderland-twist-hhs-unilateral-delay-of-regs-for-one-state/2/>.

²²⁷ H.B. 133, 2008 Leg., Gen. Sess. (Utah 2008) (enacted) (created the health system reform task force and the Utah health exchange).

²²⁸ See *supra* Part IV.A.

²²⁹ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

approval of insurance product filings.²³⁰ State regulators were concerned about duplicative processes and the potential for increased burden on insurance companies, if the federal government mandated that they use a different system for the federally run exchange than they used to submit documents to the state department of insurance.²³¹ Multiple states came together and, over time, were able to convince federal officials to allow insurers to continue to submit product filings through SERFF rather than their alternative system if a state was conducting plan management on behalf of the federally run exchange.²³²

More generally, state officials reported that they felt that if they came to the federal government with a new idea that was not prohibited under the statute or existing rules, the federal government would listen. The federal government also seemed to proactively take cues from state action: “when the federal regulations [on navigators] came out, they were fairly similar to what we had and most states had A lot of times in meetings in person, they’d ask how we were doing things and would take notes.”²³³ A former federal official confirmed this assessment: regarding states, “if you answer [a question] one way and defend it as a lawful interpretation of the ACA, the federal government won’t go against you. I don’t know of any instance of states being more adventurous when they were later told to reverse themselves.”²³⁴ While some states took a lack of

²³⁰ NAT’L ASS’N OF INS. COMM’RS, STATE SERFF MANDATES (May 7, 2015), available at http://www.serff.com/documents/state_participation_mandates.pdf; see also *About SERFF*, SERFF, <http://www.serff.com/about.htm> (last visited May 22, 2015).

²³¹ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

²³² See, e.g., Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., 2015 Letter to Issuers in the Federally-facilitated Marketplaces (Mar. 14, 2014), available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

²³³ Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld).

²³⁴ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

answers as cause for inaction on their part,²³⁵ “other states saw the lack of timely federal guidance as an opportunity.”²³⁶

Looking forward to 2017, the opportunity to apply for waivers from the ACA’s exchange and market reform rules may create more opportunities for states to indirectly shape federal policy.²³⁷ It remains to be seen how popular these waivers become, and whether they are typically used for large or small changes. With a waiver option on the table however, states may have less incentive to change the rules governing exchanges writ large and instead opt out of any rules with which they disagree, as has been the case with Medicaid.²³⁸ Yet successful waivers can set examples that lead to broader reforms, just as the ACA was in many ways inspired by a Massachusetts Medicaid waiver.²³⁹

V. EVALUATING THE STATE ROLE IN FEDERAL DECISION-MAKING ON EXCHANGES IN LIGHT OF CHANGING DYNAMICS

As the preceding Part demonstrates, states actively engaged in the decision-making process and were able to exert influence over at least some outcomes. However, the dynamics that have shaped state influence over exchange establishment in the early years of implementation are likely to change significantly as we move forward. Below, this Article briefly discusses some of the most significant changes that are on the horizon. It also suggests that some of these changes may encourage states to push for more formal procedures for making their voices heard than have dominated state-federal interactions to date.

²³⁵ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²³⁶ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

²³⁷ See, e.g., Patient Protection and Affordable Care Act § 1332, 42 U.S.C. § 18052 (2012) (waiver for state innovation).

²³⁸ Ryan, *supra* note 10, at 63 (“Over time . . . the waiver program has become the standard way that Medicaid is administered, as most states now use the waiver provisions to individually tailor the terms of their own Medicaid programs.”).

²³⁹ See, e.g., Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996, 2005 (2014); Metzger, *supra* note 7, at 602; Ryan, *supra* note 10, at 63–64.

A. A REBALANCING OF NEGOTIATING POWER

As of 2015, no new federal exchange establishment grants will be approved²⁴⁰ and exchanges are required to be financially self-sustaining.²⁴¹ While the loss of federal dollars may reduce state incentives to operate their own exchanges or to take on additional functions on behalf of federally facilitated exchanges, it may also give states more power in negotiations with the federal government. As one state official observed, “Right now [in 2014,] it’s all about the grant money [The federal government is] paying for the system one hundred percent. When the grant money runs out, I don’t see that they’ll have the same leverage with states.”²⁴² Given that exchanges are the gateway for individuals to access premium tax credits and cost-sharing reductions, the federal government will still have a role to play in oversight,²⁴³ but it may be more limited than what states experience under conditional spending programs, like Medicaid.

State officials emphasized this distinction between exchanges and Medicaid, where ongoing federal matching funds can leave states at the mercy of the federal government.²⁴⁴ According to one: “With the exchange,

²⁴⁰ Patient Protection and Affordable Care Act § 1311(a), 42 U.S.C. § 18031(a)(4)(B) (2012) (“No grant shall be awarded under this subsection after January 1, 2015.”).

²⁴¹ *Id.* § 1311(d)(6), 42 U.S.C. § 18031(d)(5)(A) (“In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.”).

²⁴² Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²⁴³ For example, the ACA requires state exchanges to keep an accurate accounting of its activities, receipts, and expenditures and to report to the Secretary of HHS annually. CMS has said that it will use this information “to assist in determining if a state is maintaining a compliant operational Exchange,” as well as to inform potential changes to priorities and approaches for future years. Agency Information Collection Activities: Proposed Collection; Comment Request, 78 Fed. Reg. 68,851, 68,852 (Nov. 15, 2013), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-11-15/pdf/2013-27305.pdf>.

²⁴⁴ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

it won't be like that. Right now it's all about the grant money [The federal government is] paying for the system one hundred percent. When the grant money runs out, I don't see that they'll have the same leverage with states."²⁴⁵ To keep states at the table or to encourage more states to elect to transition to state-based exchanges in the future, the federal government may need to be more accommodating of state demands than they are used to being.

Despite this potential boost in leverage, however, states may need a protected voice at the table going forward to avoid the federal government unitarily deciding that it does not want or need to rely on states going forward.²⁴⁶ Professors Jessica Bulman-Pozen and Heather Gerken have argued that states “wield power against a federal government that depends on them to administer its programs” and that this leverage “only increases after the federal government has devolved regulatory power to the state.”²⁴⁷ In this case, given the large number of states that have defaulted to a federally run exchange, the federal government has only partially devolved power. Perhaps with experience the federal government will determine that it can effectively and efficiently operate a centralized exchange without relying significantly on states. Already, experts have calculated that state exchanges spent 2.3 times as much per enrollee than the federal government (with the most expensive model being partnership exchanges).²⁴⁸

Indeed, Professor Abbe Gluck has argued that cooperative federalism programs like health insurance exchanges can serve a “field-claiming” function²⁴⁹ and enable the expansion of federal power in a

²⁴⁵ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²⁴⁶ As Gluck has observed, “federal agencies have almost unrestrained power to make all of the critical allocation decisions. The Court’s most recent statement at the intersection of Chevron and federalism, the *City of Arlington* case . . . , extends the deference accorded federal agencies even further, to include questions of the agency’s jurisdiction, even when state law would be affected by that decision.” Gluck, *supra* note 239, at 2028 (describing *City of Arlington v. FCC*, 133 S. Ct. 1863 (2013)).

²⁴⁷ Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256, 1266 (2009).

²⁴⁸ Amy Lotven, *Analysis Finds State Exchanges Spent More Than Twice Per Enrollee Than FFE*, INSIDE WASH. PUBLISHERS, May 7, 2014 (subscription required) (copy on file with author).

²⁴⁹ Gluck, *supra* note 131, at 574.

“below-the-radar fashion.”²⁵⁰ Some state officials expressed concern that the federal government was making moves that could be interpreted to usurp or undermine state regulators’ authority, such as the aforementioned transition policy allowing the renewal of non-ACA-compliant health plans after January 1, 2014.²⁵¹ NAIC has also recently pushed back against the federal government’s proposal to increase scrutiny of health insurer provider networks. In a public letter to the acting director of CCIIO, NAIC requested that “[b]efore CCIIO considers any changes to the current federal requirements, [it] allow the NAIC time to thoughtfully analyze this issue, and that [it] continue to look to the NAIC for guidance and continue to recognize the importance of state flexibility.”²⁵²

As state officials shared, the informality of the proceedings sometimes limited their ability to protect their interests, as they received mixed messages from different contacts²⁵³ and were denied access to legal justifications of policy decisions.²⁵⁴ Some officials are also worried about the security of their current role given that no formal agreements, like MOUs, currently exist between states regulators and the federally

²⁵⁰ Gluck, *supra* note 7, at 1756.

²⁵¹ See *supra* note 180 and accompanying text. The federal government extended this policy for two years in subsequent guidance, allowing renewals of non-ACA-compliant policies up to October 1, 2016. Letter from Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016: Extended Transition to Affordable Care Act-Compliant Policies (March 5, 2014), available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

²⁵² Letter from Adam Hamm, Monica J. Lindeen, Michael F. Consedine & Sharon P. Clark to Dr. Mandy Cohen, *supra* note 138.

²⁵³ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); see also, e.g., Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

²⁵⁴ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

facilitated exchange.²⁵⁵ Additionally, while state officials reported that they were able to take advantage of their good relationships with federal officials when CCIIO was largely staffed by former state-regulators, there is no guarantee that such relationships will continue into the future. State officials expressed concern about the recent departures of many such allies and unease about whether their replacements would be as deferential.²⁵⁶ Looking forward, state officials may feel less secure in their ability to exert their influence through informal channels if their federal counterparts do not have backgrounds working at the state-level.

B. A CHANGING PACE TO DECISION-MAKING MAY OPEN THE DOOR FOR MORE FORMAL PROCEDURES

At least some of the reliance on informal mechanisms appears to have arisen from the fast-paced nature of early years of exchange establishment. As previously documented, many proposed rules were not released until late in the implementation process, when states were busy attempting to implement their own policies and operational systems. These later rules provided increasingly shorter windows to respond, and states were given little to no advance notice when they were coming. State officials also had little confidence that their comments would matter if submitted, which made it hard for some to justify spending time on responding.²⁵⁷

Arguably, neither the federal government nor the states had time to establish and participate in formal advisory groups or negotiated rulemaking during the first few years of exchange establishment. As one state official observed, there is a “really big difference between start up and ongoing programs. For states, the first few years were really busy and I

²⁵⁵ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

²⁵⁶ See, e.g., Press Release, Nat’l Ass’n of Ins. Comm’rs, State Regulators Meet with President Obama on ACA (Apr. 17, 2014), available at http://www.naic.org/Releases/2014_docs/regulators_meet_with_obama_on_aca.htm (“State regulators expressed concern about the lack of insurance regulatory expertise with HHS Secretary Kathleen Sebelius’ departure and recommended that the appointment of a permanent director of the Center for Consumer Information and Insurance Oversight (CCIIO) be done quickly, and that the new director should rely on the expertise of state insurance regulators as decisions are made.”).

²⁵⁷ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

think everyone was just doing as much as they could There just wasn't time to put together formal advisory groups."²⁵⁸ They also noted that the lack of a stable group of people working on exchanges at the state level in the early years also likely hampered any effort to create formal advisory groups.²⁵⁹

Going forward, however, the federal government should have a cadre of experienced state exchange officials available to inform its policies and more time to engage in formal deliberations with them. The federal government could establish standing advisory committees to oversee the long-term operation of the exchange program and use negotiated rulemaking when new rules or amendments to existing rules are required.

VI. CONCLUSION

States have played a critical role in the development of federal policy and operational rules governing exchanges. They have been able to provide input through formal and informal channels, and, at times, leverage third parties including state interest groups to amplify their voice. The federal government has not always accommodated state requests, but, for the most part, has been willing to listen to their opinions. While informal communication channels have been particularly important in early years, changing dynamics may lead states to push for a more formal seat at the table in the near future.

²⁵⁸ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²⁵⁹ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

Appendix A. Methodology

This Article is informed by a broad range of resources. It examines among other things, federal rulemaking pertaining to health insurance exchanges and state comments submitted in response to these rules and other solicitations published in the *Federal Register*. This process inherently involved arbitrary decisions over how broadly to define “exchange-related.” In some cases, I have chosen to include arguably tangential rules, such as rules primarily governing things such as Medicaid eligibility,²⁶⁰ premium tax credit eligibility,²⁶¹ and premium stabilization programs,²⁶² because they were released at the same approximate time as rules directly governing exchanges and states frequently responded to them collectively. In addition, some rules were issued as “omnibus” rules and while they may predominantly deal with issues not specific to exchanges, they address some provisions that tie back to exchanges.²⁶³ Appendix B

²⁶⁰ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Proposed Rule, 76 Fed. Reg. 51,148 (proposed Aug. 17, 2011) (to be codified at 42 C.F.R. pts. 431, 433, 435, 457); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule, 77 Fed. Reg. 17,144 (proposed Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 457).

²⁶¹ Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931 (proposed Aug. 17, 2011) (to be codified at 26 C.F.R. pt. 1); Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377 (proposed May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602); Health Insurance Premium Tax Credit, 78 Fed. Reg. 7,264 (proposed Feb. 1, 2013) (to be codified at 26 C.F.R. pt. 1); Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25,909 (proposed May 3, 2013) (to be codified at 26 C.F.R. pt. 1).

²⁶² Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 76 Fed. Reg. 41,930 (proposed July 15, 2011) (to be codified at 45 C.F.R. pt. 153); Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 77 Fed. Reg. 17,220 (proposed Mar. 23, 2012) (to be codified at 45 C.F.R. pt. 153).

²⁶³ See, e.g., Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4,594 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. pts. 430, 431, 433, 435, 440, 447, 457, 45 C.F.R. pt. 155); Medicaid and Children’s Health Insurance Programs:

includes information on the rules and other solicitations that I reviewed for this Article.

The process of finding state responses to comment solicitations posted in the *Federal Register* is also somewhat imprecise. Public comments are typically posted on Regulations.gov shortly after their submissions. While submission forms typically include a field where respondents can identify themselves (e.g., individual, academic, health care association, state government, etc.), comments are not sortable by these categories. In some cases, upwards of multiple thousands of responses were submitted to exchange-related solicitations. I have attempted to be thorough in my review of responses to identify comments from state officials or state interest groups, such as the NAIC. However, it is possible that I missed some due to my own error or technical errors with the website.

I also had to draw lines over what I chose to collect and report on. For this Article, I counted any comments submitted by state governors' offices or administrative agencies (such as departments of insurance or Medicaid agencies), state-based exchanges, and any legislative committees or task forces formed specifically to consider or monitor health care reform implementation. I did not include comments from individual state legislators, members of Congress, or local or municipal entities. Furthermore, the state response numbers I report below are based on whether any of the counted state entities responded to a solicitation. Frequently, multiple entities within a state would submit letters (or a single entity may submit multiple comment letters or documents). I do not individually count each of these instances. Appendix C documents these findings.

In addition, I conducted interviews with twenty state officials, two representatives of state interest groups, and two former federal officials to inform my findings and observations.²⁶⁴ State officials include representatives of both state-based exchanges and the different variations of federally facilitated exchanges. Because of the sensitive nature of some of

Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160 (proposed July 15, 2013) (to be codified at 42 C.F.R. pts. 431, 435, 436, 438, 440, 447, 457, 45 C.F.R. pts. 155, 156).

²⁶⁴ I also contacted a small number of current federal officials requesting interviews, but did not receive any responses.

their disclosures I have attempted to anonymize any quotes. Any references to specific states are based on publicly available information.

Appendix B. Federal Rulemaking & Solicitations, March 23, 2010 - May 30, 2014

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Planning & Establishment of State-Level Exchanges; RFC Regarding Exchange-Related Provisions in Title I of the PPACA	RFC	OCHIO	2010-Aug-03	Y	62	N
Application, Review, & Reporting Process for Waivers for State Innovation	PR	CMS; Treas	2011-Mar-14	Y	60	N
PPACA; Establishment of Exchanges and QHPs; Exchange Standards for Employers; PR	PR	HHS	2011-July-15	Y	108*	Y
PPACA; Standards Related to Reinsurance, Risk Corridors & Risk Adjustment	PR	HHS	2011-July-15	Y	108*	Y
Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers	PR	HHS	2011-Aug-17	Y	75	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010	PR	CMS	2011-Aug-17	Y	75	Y
Health Insurance Premium Tax Credit	NPRM	IRS	2011-Aug-17	Y	75	N
Application, Review, & Reporting Process for Waivers for State Innovation	FR	CMS; Treas	2012-Feb-27	N	N/A	N
Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010	FR; IFR	CMS	2012-Mar-23	Y	45	Y
PPACA; Standards Related to Reinsurance, Risk Corridors & Risk Adjustment	FR	HHS	2012-Mar-23	N	N/A	N
PPACA; Establishment of Exchanges and QHPs; Exchange Standards for Employers; FR & IFR	FR; IFR	HHS	2012-Mar-27	Y	45	Y
Health Insurance Premium Tax Credit	FR	IRS	2012-May-23	Y	90	N

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Data Collection to Support Standards Related to EHBs; Recognition of Entities for the Accreditation of QHPs	PR	HHS	2012-June-05	Y	30	Y
Data Collection to Support Standards Related to EHBs; Recognition of Entities for the Accreditation of QHPs	FR	HHS	2012-July-20	N	N/A	Y
Recognition of Entities for the Accreditation of QHPS	N	HHS	2012-Nov-23	N	N/A	N
PPACA, Standards Related to EHBs, Actuarial Value, & Accreditation	PR	HHS	2012-Nov-26	Y	30	Y
RFI Regarding Health Care Quality for Exchanges	RFI	CMS	2012-Nov-27	Y	30	N
HHS Notice of Benefit & Payment Parameters for 2014	PR	CMS	2012-Dec-07	Y	24	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Medicaid, CHIP, & Exchanges: EHBs in Alternative Benefit Plans, Eligibility Notices, Fair Hearing & for Medicaid and Exchange Eligibility Appeals & Other Provisions Related to Eligibility & Enrollment for Exchanges, Medicaid & CHIP, & Medicaid Premiums & Cost Sharing; PR	PR	CMS	2013-Jan-22	Y	22	Y
PPACA; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions	PR	CMS	2013-Feb-01	Y	45	Y
Health Insurance Premium Tax Credit	FR	IRS	2013-Feb-01	N	N/A	N
PPACA, Standards Related to EHBs, Actuarial Value, & Accreditation	FR	HHS	2013-Feb-25	N	N/A	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA; HHS Notice of Benefit & Payment Parameters for 2014 & Amendments to the HHS Notice of Benefit & Payment Parameters for 2014; FR; PPACA; Establishment of & QHPs; SHOP; PR	FR	CMS	2013-Mar-11	N	N/A	Y
PPACA, Amendments to the HHS Notice of Benefit & Payment Parameters for 2014	IFR	CMS	2013-Mar-11	Y	50	N
PPACA, Establishment of Exchanges & QHPs; SHOP	PR	CMS	2013-Mar-11	Y	21	Y
PPACA, Exchange Functions: Standards for Navigators & Non-Navigator Assistance Personnel	PR	CMS	2013-Apr-05	Y	31	Y
Minimum Value of Eligible Employer-Sponsored Plans & Other Rules Regarding the Health Insurance Premium Tax Credit	NPRM	IRS	2013-May-03	Y	60	N

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA, Establishment of Exchanges & QHPs; SHOP	FR	CMS	2013-June-04	N	N/A	Y
PPACA; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, & Market Standards; PR	PR	CMS	2013-June-19	Y	30	Y
PPACA; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; FR	FR	CMS	2013-July-01	N	N/A	Y
Information Reporting for Affordable Insurance Exchanges	NPRM	IRS	2013-July-02	Y	63	N
Medicaid & CHIP: EHBs in Alternative Benefit Plans, Eligibility Notices, Fair Hearing & Appeal Processes, & Premiums & Cost Sharing; Exchanges: Eligibility & Enrollment; FR	FR	CMS	2013-July-15	N	N/A	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA; Exchange Functions: Standards for Navigators & Non-Navigator Assistance Personnel; Consumer Assistance Tools & Programs of an Exchange & Certified Application Counselors; FR	FR	CMS	2013-July-17	N	N/A	Y
PPACA; Program Integrity: Exchange, SHOP, & Eligibility Appeals; FR	FR	CMS	2013-Aug-30	N	N/A	Y
Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of QHPs	N	CMS	2013-Sep-13	Y	32	N

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA; Program Integrity: Exchange, Premium Stabilization Programs, & Market Standards; Amendments to the HHS Notice of Benefit & Payment Parameters for 2014; FR	FR	CMS	2013-Oct-30	N	N/A	Y
PPACA; Exchanges & QHPs, Quality Rating System (QRS), Framework Measures & Methodology	NWC	CMS	2013-Nov-19	Y	63	N
PPACA; HHS Notice of Benefit & Payment Parameters for 2015; PR	PR	CMS	2013-Dec-02	Y	24	Y
PPACA; Maximizing January 1, 2014 Coverage Opportunities	IFR	CMS	2013-Dec-17	Y	6	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Health Insurance Exchanges; Approval of an Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of QHPs	FN	CMS	2013-Dec-23	N	N/A	N
PPACA; HHS Notice of Benefit & Payment Parameters for 2015; FR	FR	CMS	2014-Mar-11	N	N/A	Y
PPACA; Third Party Payment of QHP Premiums	IFR	CMS	2014-Mar-19	Y	60	Y
PPACA; Exchange and Insurance Market Standards for 2015 & Beyond; PR	PR	CMS	2014-Mar-21	Y	31	Y
Information Reporting for Affordable Insurance Exchanges	FR	IRS	2014-May-07	N	N/A	N
PPACA; Exchange & Insurance Market Standards for 2015 & Beyond; FR	FR	CMS	2014-May-27	N	N/A	Y

CHIP=Children's Health Insurance Programs
CMS=Centers for Medicare & Medicaid Services
EHB=Essential Health Benefit
FIS=Federalism Impact Statement
FN=Final Notice
FR=Final Rule
HHS=Department of Health and Human Services
IFR=Interim Final Rule
IRS=Internal Revenue Services
N=Notice
NPRM=Notice of Proposed Rulemaking
NWC=Notice with Comment
OCIIO=Office of Consumer Information and Insurance Oversight
PR=Proposed Rule
PPACA= Patient Protection and Affordable Care Act
QHP=Qualified Health Plan
RFC=Request for Comments
RFI=Request for Information
SHOP=Small Business Health Options Program

* The original comment period for this proposed rule was seventy-five days. However, the federal government subsequently extended it to 108 days. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Extension of Comment Period, 76 Fed. Reg. 60,788–89 (Sept. 30, 2011) (codified at 45 C.F.R. pts. 153, 155, 156).

Appendix C. State Participation in Notice-and-Comment Rulemaking

	Request for Comments Regarding Exchange-Related Provisions ... (8/3/10)	Application, Review, and Reporting Requirements for Waivers... (3/14/11)	Establishment of Exchanges and Qualified Health Plans (7/15/11)	Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (7/15/11)	Exchange Functions in the Individual Market... (8/17/11)	Eligibility Changes Under the Affordable Care Act of 2010 (8/17/11)	Health Insurance Premium Tax Credit (8/17/11)	Eligibility Changes Under the Affordable Care Act of 2010 (IFR) (3/23/12)	Establishment of Exchanges and Qualified Health Plans... (IFR) (3/27/12)	Data Collection to Support Standards Related to Essential Health Benefits... (6/5/12)	Standards Related to Essential Health Benefits, Actuarial Value... (11/26/12)	Request for Information Regarding Health Care Quality for Exchanges (11/27/12)	HHS Notice of Benefit and Payment Parameters for 2014 (12/7/12)	Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices... (1/22/13)	Exchange Functions: Eligibility for Exemptions... (2/1/13)	Exchange Functions: Standards for Navigators... (4/5/13)	Minimum Value of Eligible Employer-Sponsored Plans and Other Rules... (5/3/13)	Program Integrity: Exchange, SHOP, Premium Stabilization Programs... (6/19/13)	Information Reporting for Affordable Insurance Exchanges (7/2/13)	Exchanges and Qualified Health Plans, Quality Rating System... (11/19/13)	HHS Notice of Benefit and Payment Parameters for 2014 (12/2/13)	Exchange and Insurance Market Standards for 2015 and Beyond (3/21/14)	Third Party Payment of QHP Premiums (3/19/14)
AL	X	-	-	-	X	X	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
AK	-	-	-	-	-	X	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	-	-
AZ	-	-	-	X	-	X	-	X	-	-	-	-	X	X	-	X	-	-	-	-	-	-	-
AR	X	-	X	-	-	X	-	-	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-
CA	X	-	X	X	X	X	X	X	-	-	X	-	X	X	X	X	-	-	-	X	-	-	X
CO	X	-	X	-	X	X	X	-	-	-	X	X	-	X	-	X	-	-	X	-	-	-	X
CT	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	X	-	-
DE	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	-	-	X	X	X	X	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
FL	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
GA	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	X	X	-
HI	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-
ID	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	X
IL	X	-	X	X	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
IN	-	X	X	X	X	X	X	-	-	X	-	-	-	-	-	-	-	-	-	-	-	X	-
IA	-	-	X	X	X	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
KS	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	X	X	-
KY	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-
LA	X	-	X	-	X	X	-	X	X	-	X	-	X	X	-	X	-	-	X	-	X	-	-

