Where the Rubber Meets the Road:

Strategies for Successful State Implementation of the Affordable Care Act

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Health Care for America Now (HCAN) is a national coalition of more than 1,000 groups in 46 states representing 30 million people that led the grassroots effort to pass the Affordable Care Act in 2010. We run comprehensive issue campaigns that mobilize people at the grassroots and define the public debate. HCAN and our 501(c)(3) partner, Health Care for America Education Fund, are now working to implement and improve the new health care law through national and state-based legislative and regulatory campaigns that rely on grassroots action, public education, aggressive communications, ground-breaking research, and policy analysis. www.healthcareforamericanow.org

Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. http://healthyamericans.org

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Executive Summary

The Patient Protection and Affordable Care Act (ACA), which became law on March 23, 2010, holds the promise of providing affordable health care to more than 30 million Americans who now lack coverage, improving coverage for tens of millions more, and relieving families of the lingering burden of medical debt. The ACA also has the potential to promote greater racial and economic justice. Poor health — to the extreme of shorter life expectancy — profoundly impacts people's ability to realize their full potential as individuals and within society. Access to affordable health care can have a profound impact not only on people's health, but also on their ability to lift themselves out of poverty and achieve a higher standard of living.

The ACA holds the promise of providing affordable health care to more than 30 million Americans who now lack coverage, improving coverage for tens of millions more, and relieving families of the lingering burden of medical debt.

The ACA gives states significant policy discretion in implementing the law within a framework established at the federal level. As a result, realizing the promise of the ACA will depend on the results of a complex interplay between federal and state policymaking, which will occur in a polarized political environment. This paper focuses on the environment, policy issues, strategies and activities consumer advocates must pursue at the state level to support successful implementation, as well as on the role of national organizations in supporting that work.

A group of five foundations[1] asked six national organizations[2] to come together and propose a plan for effective state implementation of the ACA. The California Endowment made a grant to Community Catalyst to fund the project.

This paper, including the information contained in the appendices, seeks to accomplish the following objectives:

- Describe the policy terrain in which state implementation of the ACA is occurring and key policy issues that are stake
- Propose a specific strategy for successful state implementation of the ACA

This paper proposes the following three strategies for supporting state implementation of the ACA:

1. Creating the best possible environment for implementation through work on both the national and state levels
2. Creating sufficient state capacity and infrastructure to support the implementation of the ACA through an investment strategy that maximizes effectiveness across a number of states with varying environments
3. Investing in the capacity of national organizations to allow them to support state implementation and effectively coordinate implementation efforts among and between national and state organizations

The federal policies developed to implement the ACA, which will set the parameters for state actions, are an essential foundation for the state work. Policy advocacy at the national level will thus have a great impact on what happens in the states and will require substantial effort. In addition, while most of the work necessary to successfully implement the ACA — including advocacy around federal and state legislative activity —

can be carried out by 501(c)(3) organizations, some of the work will include activities that must be carried out by 501(c)(4) organizations. However, both of these topics are outside the scope of this paper. (A brief paper describing the role of social welfare 501(c)(4) organizations in achieving successful implementation of the ACA is available from Health Care for America Now.)

Major Provisions of the Law

The ACA addresses a broad range of health care issues. Coverage expansion is addressed through a major expansion of Medicaid and by providing premium subsidies to low- and middle-income people (in the form of income-based tax credits) through new, regulated insurance marketplaces called Exchanges. New insurance regulations coupled with the creation of insurance Exchanges will promote quality coverage for children and adults and improve affordability, transparency, efficiency and fairness for individuals and small businesses that obtain coverage there. The ACA also imposes a responsibility on most individuals and many employers to contribute to the cost of coverage.

These coverage provisions, far-reaching though they may be, are only part of the law. The ACA also contains a cost control and quality improvement strategy based on the development of clinical models supported by appropriate reimbursement methods designed to reduce preventable hospitalizations and ineffective treatments. The ACA also makes significant new investments in public health to reduce disease incidence. It offers the nation an opportunity to begin to correct longstanding racial and ethnic inequalities in health care and health status. The ACA strengthens the requirements on hospitals to provide financial assistance to people in need, an important interim step on the road to expanded coverage, but one that will remain important even after implementation is complete.

The ACA gives states the option to administer the law themselves or turn responsibilities over to the federal government.

The ACA also give states the option to decline to administer certain provisions of the law. For example, they can choose to have the federal government run their Exchange rather than administering it themselves. States also have opportunities to innovate, for example, by designing integrated health delivery systems or including a public option in their Exchange.

The Environment for Implementation

Without diminishing the historic importance of the passage of the ACA, it is important to recognize the fragile nature of what has been achieved so far, as well as the challenges, both political and substantive, that lie ahead. Several critical environmental challenges must be met before we can definitively know that the ACA will realize its historic promise of vastly diminishing health care inequality and beginning to slow the growth of health care costs.

One of these challenges is the significant time lag between passage of the law and full implementation of the major coverage provisions and market reforms. Many provisions will not be fully implemented for four years, and some will take as long as seven. During this interim period, and especially while states are in fiscal crisis, Medicaid, a key foundation for expanded coverage under the ACA, will be under enormous pressure, as will programs that in recent years have substantially increased coverage for children. Another

challenge is that two intervening federal elections occur between the passage of the law and when most of the reforms go into effect. The recent election resulted in leadership much less committed to its implementation in Congress and many state houses. Continuing partisan divisions over the ACA are likely to intensify in the near term, as opponents wage an active campaign to reduce public support for the law and nullify some portions of it altogether. A third challenge is the scope and complexity of the law, which makes it hard for the public to understand it. Public opinion remains divided on the law, with opponents more intense in their feelings than supporters.

How the ACA Will Be Administered

The ACA is structured as a joint federal-state initiative. It includes substantial federal funding and requirements, but vital components — particularly those that most directly affect the expansion of coverage to the uninsured — will require state legislation and will be administered primarily by the states. The major state responsibilities include setting up insurance Exchanges for small businesses and individuals; determining the subsidy eligibility for millions of people to buy coverage in the Exchanges; enforcing the new insurance reforms; and overseeing the new Medicaid expansion. States will also have to meet new administrative challenges such as reaching out to enroll new populations; integrating Medicaid and CHIP with the new Exchanges; and applying new Medicaid and CHIP income eligibility standards established under the law.

The success of implementation in each state will depend on the policy choices it makes and its willingness to allocate sufficient resources.

The success of implementation in each state will depend in large part on the policy choices it makes, and its willingness to allocate sufficient financial resources and staffing. States will need to implement the ACA while facing, over the next two fiscal years, an estimated $235 billion budget deficit. In addition, many states have recently elected new governors, and many of those governors campaigned against the ACA. In short, states will need to gear-up for implementation in a fluid political environment and at a time when resources are very constrained. Moreover, federal decisions on a vast array of the ACA issues will heavily influence the states' ability to successfully implement the law. In many cases, these federal rules will set requirements with which states will have to comply. National organizations will need to engage in substantial work on federal policy issues, conducting detailed analysis of the law and its various policy options, consulting state and local groups and relevant experts, designing and assessing policy alternatives, organizing coalitions to promote the most favorable options, and engaging with policy-makers in agencies across the administration. This important work (except insofar as it involves enlisting the help of state advocacy organizations on these matters) lies outside the scope of this paper.

Need for Effective Advocacy

The many obstacles outlined above create substantial risk that in a number of states the ACA will be implemented poorly and fall far short of its promise. Furthermore, industry groups, although not uniformly opposed to the ACA, will be working to influence implementation in their own self-interest. These include health insurance and pharmaceutical companies and health care providers such as hospitals, physicians and nursing

homes. In this environment, state advocacy groups will need to play a significant role to ensure that implementation is successful. The inclusion of trusted local voices will be critical in this effort. Sustained, coordinated engagement by advocates across time and venue (local, state and federal) will be essential, and advocates will need to engage in a wide range of advocacy activities, including public education; administrative and legislative advocacy; shoring up and expanding public support for the ACA; and analyzing and addressing the many policy issues, options, and complications of implementation.[3]

Accomplishing these tasks will require a variety of skills. State advocates will need to: develop effective coalitions and strategies, both to ensure the ACA is implemented properly and to avert short-term budget cuts in safety-net programs for adults and children; work in partnership with national groups to make informed decisions on federal and state implementation issues; form relationships with other stakeholders (including insurers, where possible) across a range of issues; and create robust consumer assistance and support programs to help people navigate the new system.

A Strategy for Successful Implementation of the ACA

For all of the reasons described above, successful state implementation of the ACA requires attention to both substantive policy issues and the broader public debate. Addressing both dimensions will require the following:

1. **Creating the best possible environment for implementation**
   Creating a positive environment requires close attention to the overall public discourse about the ACA and targeting communications to the most "persuadable" demographic groups. These include seniors, small businesses, communities of color (particularly Latinos), women, parents with young adult children and children with special health care needs, people with disabilities, and people with chronic illnesses. Members of these groups need to become messengers to a broader audience to explain what the ACA will really do. To begin to take on this role, they need first to be informed about the benefits available to them from early implementation measures.

Building public support will require effective communications frames and integrated issue campaigns at the state and national levels.

   Building public support will also require the development of effective communications frames and the creation of integrated issue campaigns at the state and national levels. Advocates must be able to forcefully expose and refute false claims and arguments made by opponents attacking the law. They must be able to respond rapidly to distortions and misinformation put forward by those who would like to see the law fail.

2. **Creating sufficient capacity and infrastructure in states with a variety of environments**
   Significant investment is needed to develop the capacities of state organizations, both in states with long-established infrastructures and those with little or none. Maintaining current levels of support is critical to sustaining core capacities. Additional resources will be needed to expand advocacy efforts to more states and allow advocates to develop new expertise and capacities and handle the increasing volume of work. State advocacy organizations must be able to analyze policy options and advocate for policy positions, conduct legal analysis, build coalitions, organize

the grassroots and netroots[4], develop communications efforts, carry out strategic campaigns, raise funds, and monitor and provide feedback on implementation efforts. Groups will need to develop relationships with elected, appointed and career state officials and gain access to influential opinion leaders involved in implementation efforts.

The number of groups working on various aspects of ACA implementation will differ from one state to another, depending on the depth and breadth of the advocacy community. In all states, advocates should seek to establish a consumer implementation "table" that brings together the various state partner organizations working on ACA implementation. These may include, for example, health care and low-income advocacy groups; state fiscal policy groups; children's advocacy organizations; multi-issue grassroots organizations and networks; faith groups; labor unions; the public health and prevention community; and groups representing communities of color, seniors, women and people with disabilities and chronic health conditions. The goals for these entities could include:

- sharing information on policy issues and best practices
- developing common policy agendas and identifying and negotiating over differences
- sharing information about state policy regulators and policymakers and designing coordinated approaches when appropriate
- sharing information about state and national issue campaigns that groups are undertaking
- coordinating communications and public education strategies, including the development of effective messages and establishment of media and editorial relationships
- developing state implementation campaigns that include multiple participants in the implementation "table"

In addition to maintaining and building capacity within states, cross-state communication has the potential to yield greater benefits than in any previous period. As states simultaneously confront similar implementation challenges, it is important to capture the lessons learned in one state and facilitate their transfer to others, particularly those with similar political or policy environments. This is one of the technical assistance functions that national groups can perform.

3. Investing in national groups that can support and help coordinate state advocacy efforts

State partners will need help navigating the complex policy environment created by the ACA. National and state groups will need to work together to analyze state policy issues and options, and to gather and analyze information about the experiences in a range of states. To maximize effectiveness at the state level, national organizations need to develop and support state advocates by providing information about best practices — not only on policy issues but also on communications, campaign planning, mobilization, and litigation strategies. National advocacy groups can improve their technical assistance by:

National and state groups will need to work together to analyze state policy issues and options, and to gather and analyze information about the experiences in a range of states.

- identifying and, when possible, resolving substantive or strategic differences among national organizations
- coordinating and aligning their communications with state partners to minimize conflicting policy, messaging and political advice, as well as calls to action
- coordinating activities across issue areas

A number of national groups have already begun to collaborate on early implementation issues, and some national groups with similar or complementary policy priorities or missions are now discussing and developing more formal collaborations that hold significant promise.

Recommendations for Funding State Advocacy

Although work is required in all 50 states and the District of Columbia, limited resources necessitate some targeting of efforts. We recommend an approach that, based on the following criteria, invests in a range of states with varying environments.

- **Positive path breakers:** States most likely to positively and robustly implement the ACA
- **Negative path breakers:** States with a greater likelihood of poorly implementing the ACA or where efforts to repeal or undermine the ACA are strong
- **Strong advocacy capacity:** States with strong consumer advocacy organizations that can be effective leaders in implementation efforts
- **Local funder partners:** States with local funders willing to match national investments
- **High need:** States with a high proportion of low-income uninsured and high rates of racial and ethnic health disparities
- **High impact:** States with the greatest number of people who will benefit from the ACA, such as states with large numbers of uninsured

The best approach should target a mix of states with one or more of the attributes described above. In selecting states, geographic diversity is an important consideration. Geographic diversity is advantageous because lessons learned in one state are often more easily transferred to neighboring states.

We further recommend that funding go to existing state organizations that have an in-depth knowledge of the specific politics, policies and cultures of their states, and that have developed or have the potential to develop the capacities, experience and relationships necessary to carry out the work that implementation will require.

We believe that a coordinated national and state advocacy effort is essential to successful ACA implementation, which in turn is vital to advancing a broader agenda whose aim is to attain a more fair and just society. This plan is designed to serve as an important component of this critical effort.

Section I: Introduction

The Patient Protection and Affordable Care Act (ACA), which became law on March 23, 2010, holds the promise of providing affordable access to health care for more than 30 million Americans who now lack coverage, improving coverage for tens of millions more, and relieving families of the lingering burden of medical debt. The ACA also has the potential to promote greater racial and economic justice. Poor health — to the extreme of shorter life expectancy — affects people's ability to realize their full potential as individuals and within society. Access to affordable health care can have a profound impact not only on people's health, but also on their ability to lift themselves out of poverty and achieve a higher standard of living.

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The ACA gives states significant policy discretion in implementing the law within a framework established at the federal level. As a result, realizing the promise of the ACA will depend on the results of a complex interplay between federal and state policymaking, which will occur in a polarized political environment. This paper focuses on the environment, policy issues, and strategies and activities that consumer advocates must pursue at the state level to support successful implementation of the ACA, as well as on the role of national organizations in supporting that work.

The paper was written at the request of five foundations that have made significant investments in state and federal work on health care reform: Atlantic Philanthropies; The California Endowment; The David and Lucile Packard Foundation; The Nathan Cummings Foundation; and The Robert Wood Johnson Foundation. The foundations asked six organizations to come together and propose a plan for effective state implementation of the ACA. The organizations are the Center on Budget and Policy Priorities, Community Catalyst, Families USA, Georgetown University Center for Children and Families, Health Care for America Now, and Trust for America's Health. The California Endowment made a grant to Community Catalyst to fund the project.

The ACA is the most complex and far-reaching social legislation enacted in the United States in decades. Important provisions of the ACA began taking effect in 2010, but the central provisions that expand coverage to the uninsured and establish new health insurance markets do not go into effect until 2014. Successful implementation will take a concerted, robust effort at the federal and state levels throughout the four years leading up to 2014, as well as in the years that follow.

The goal of this paper is to recommend the most effective ways to support implementation of the ACA at the state level. The ACA is structured as a joint federal-state initiative. It includes substantial federal funding and requirements, but vital components — particularly those that most directly affect the expansion of coverage to the uninsured — are administered primarily by states. The success of implementation in each state will depend in large part on the policy choices the state makes and on its willingness to devote sufficient financial resources and staffing to implementation. At the same time, federal decisions on a vast array of ACA issues will heavily influence the ability of states to successfully implement the law.

This paper, including the information contained in the appendices, seeks to accomplish the following objectives:

- Propose a specific strategy for successful state implementation of the ACA
- Describe the policy and political terrain in which state implementation of the ACA is occurring and key policy issues at stake

The paper proposes the following three strategies for supporting state implementation of the ACA:

1. Creating the best possible environment for implementation of the ACA by:
   - Educating the public, with a focus on critical target populations such as seniors, small businesses, communities of color (particularly Latinos), women, parents with young adult children and children with special health needs, and people with disabilities and chronic illnesses
   - Developing communications frames and mounting integrated issue campaigns nationally and at the state level
   - Refuting and exposing false claims, including rapidly responding to opposition efforts

2. Creating sufficient capacity and infrastructure in states with a variety of environments to allow state advocates to:
   - Maintain current levels of effort as well as carry out the additional activities that implementation will require
   - Establish mechanisms for groups to coordinate work on implementation — a state ACA implementation working group or other similar mechanism appropriate for that state
   - Communicate and share learnings with other states

3. Investing in national groups to allow them to support state advocates and coordinate implementation efforts among states by:
   - Analyzing and coordinating work on policy issues and options among themselves and with state advocates
   - Coordinating technical assistance to state advocates in various issue areas and across functions such as policy analysis, communications and messaging, campaign development, advocacy, and legislative activities

Section II: The Promise and Challenge of the ACA

"Of all the forms of injustice, inequality in health care is the most shocking and inhumane."
—Dr. Martin Luther King, Jr.

The word "inequality" aptly characterizes the health care system in the United States. On a per capita basis, the U.S. on average spends twice as much on health care as other industrialized countries, yet denies care to tens of millions of people and places huge financial stress on millions of others.

Dr. King's observation also points to the relationship between inequality in health care and other forms of injustice. The consequences of lack of access to quality health care deeply affect people's well-being, including in ways that extend beyond their "health." For example, more than half of personal bankruptcies are caused in part by medical debt. Even for those who don't experience this extreme effect, unaffordable medical expenses can drain their savings and undermine their financial stability.[5]

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The Institute of Medicine also found that the negative effects of lack of insurance extend beyond individuals to entire communities, especially those where many residents are uninsured.[6] Other research shows that the United States, which ranks at the bottom among industrial nations in terms of health equality, also experiences a greater incidence of a variety of other social ills, such as obesity and mental illness.[7]

Successful implementation of the ACA has the potential to vastly improve the well-being of our nation as a whole and its most vulnerable residents. In the ACA, coverage expansion is achieved through relatively progressive methods, and the benefits of the law are greatest for groups at the bottom of the income scale. By improving both the affordability and quality of health insurance coverage, the ACA will help reduce the incidence of medical debt, which weighs most heavily on female-headed households and communities of color, and make it easier for people to lift themselves out of poverty, achieve a higher standard of living, and accumulate assets. The elimination of gender rating, improvements in access to interpreters in medical settings, and specific strategies to reduce racial and ethnic health disparities, will also contribute to an overall reduction of inequality. While far from a cure-all, successful implementation of the ACA is likely to have a positive impact on many social ills beyond its impact on health.

But whether and to what extent the new promise of affordable health care will be realized remains an open question. The process of implementing a complex law — one that creates significant new responsibilities for the federal government, state governments, individuals and businesses — is extremely challenging. If all involved had the same agenda and the very best of intentions, successful implementation would still be challenging. In the real world, where people have conflicting agendas and resources are scarce, the task is daunting. Without in any way diminishing the historic importance of the passage of the ACA, it is important to recognize the fragile nature of what has been achieved so far, as well as the challenges that lie ahead. Several critical environmental challenges

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must be met before we can definitively know the ACA will fulfill its historic promise of vastly diminishing health care inequality. Failure to meet these challenges could result in defunding of the law, or even its repeal.

One of these challenges is the significant time lag between passage of the law and full implementation of the major coverage provisions and market reforms. Many provisions will not be implemented for four years, and some will take as long as seven. During this interim period when states are in fiscal crisis, Medicaid, a key foundation for expanded coverage under the ACA, will be under enormous pressure. One particular concern is that some states may abandon successful efforts to further simplify enrollment or expand outreach, particularly to additional eligible but unenrolled children, and may also seek to make other harmful cuts to Medicaid benefits or rates. The time lapse between passage of the law and its implementation also creates a period during which false and misleading assertions about the harmful effects of the ACA can be raised. While proponents of the ACA can rebut these claims, they will not be able to disprove them by pointing to real world gains. Because of this, progress in winning public support will be slow.

Another challenge that arises from the time lapse until full implementation is the possibility of diminished political support for the ACA. We have recently seen this in the wake of the November election that saw an increase in office holders opposed to the law at the federal and state levels.[8]

Massachusetts, which has provided so many useful lessons with respect to the structure of reform, offers a cautionary lesson. The first Massachusetts Universal Health law, which was enacted in 1988, included a four-year phase-in period. However a weak economy and a change in executive leadership prevented the law from ever being fully implemented, and its most far-reaching component, an employer responsibility requirement, was repealed in 1996. Partly in response to this lesson, the state ensured that the new subsidized coverage included in its groundbreaking 2006 health reform law became available soon after the law's passage. The 1988 Medicare catastrophic care insurance program offers another cautionary tale of a law that Congress passed and was forced to repeal in the face of organized opposition.[9]

A third challenge is the extremely polarized nature of the political debate that preceded passage of the ACA. While these divisions may decrease over time as more people become engaged in implementing the law, in the near term they will complicate the task of implementation because of the impossibility of making technical corrections to the law at the federal level. An additional challenge is the scope and complexity of the law, which makes it hard for the public to understand. The findings of public opinion polls since passage of the ACA have varied modestly, but in the aggregate they tend to indicate an electorate that is highly divided over the measure.

The best available evidence demonstrates that opponents' major concerns are unfounded. While one of their principal concerns is that the law is not paid for and will add to the deficit, the Congressional Budget Office's (CBO) analysis shows the opposite (and it has a track record of underestimating the type of health savings, particularly in Medicare, that are included in the legislation).[10] However, perhaps transcending any specific concern is the public's pervasive lack of trust in government itself. The Pew Research Center for the People and the Press reports that trust in government is at its lowest since 1994[11], when it first began tracking the measure. As a result, significant improvement in public

support for the ACA is unlikely to occur until the law is more fully implemented, positive benefits begin to flow, and dire consequences fail to materialize.

While the implementation environment is indeed daunting, there are some significant bright spots. First, there is a higher degree of engagement and coordination among organizations supporting reform than has ever existed before. Second, there is widespread recognition within the health care industry that the status quo is unsustainable and that the professional and economic interests of many of the organizations that shape health policy are better served by successfully implementing the ACA than by its repeal. Third, over the period of implementation, the economy is likely to improve, easing some of the pressure on state budgets. Finally, through the Department of Health and Human Services (HHS) and other agencies, the White House is making an aggressive effort to promote the law's benefits and continue a national campaign to build support.

One implication that can be drawn from this review of the environment in which implementation of the ACA will take place is the need for sustained, coordinated advocacy across time and venue (local, state and federal). Advocates will need to engage in a wide range of activities, including educating the public; intervening with administrative and legislative policymakers; shoring up and expanding public support for the ACA; maintaining Medicaid expansions and protecting the gains that have been made in covering children; and analyzing and addressing the many policy issues, options, and complications of implementation. Another is the need for advocates to seek alliances with industry stakeholders on issues where this is feasible (one fruitful opportunity is likely to be maximizing enrollment in new programs, perhaps the ACA topic with the broadest potential for building consumer-industry alliances), even while recognizing that on other issues the interests of consumers and other stakeholders may conflict. Seeking such alliances is based on acknowledgement of the industry's important role in shaping both public opinion and the views of decision makers. (More specific recommendations for addressing the challenges of implementation are discussed in Section IV.)

One implication that can be drawn from this review of the environment is the need for sustained, coordinated advocacy across time and venue – local, state and federal.

Section III: State and Federal Roles in Implementation of the ACA

Some major social programs in the United States, such as Social Security and Medicare, are completely funded and administered at the federal level. Others, such as Medicaid and CHIP, are run jointly by the federal government and the states — the federal government sets standards and guidelines and provides some or most of the funding, but states have considerable flexibility in how the program is administered or designed within the state. The ACA relies heavily on the joint federal-state model, in which the federal government provides funding and sets requirements but leaves administration of vital components of the law — particularly those that most directly affect the expansion of coverage to the uninsured — primarily to the states. John McDonough, who served on the Senate Health, Education,

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Labor and Pensions Committee staff when the bill was written, observed about the Senate version of the reform bill that ultimately became law:

> *The Senate crafted a version that gives a clear right of first refusal to states to lead in implementation consistent with federal rules and guidance. As such, at least half the 'real action' over the coming years will occur in states, most of which are still climbing out of the depths of the economic downturn. There is a critical need for focused support to states, both in and out of government, to achieve the requirements for successful national health reform.*

The major responsibilities for states include setting up insurance Exchanges for small businesses and individuals; determining the eligibility of millions of people for subsidies to buy coverage in the Exchanges; enforcing the new insurance reforms; and overseeing the new Medicaid expansion, which for the first time will provide coverage to all low-income people whether or not they have children. States will also have to meet new administrative challenges such as reaching out to enroll new populations, integrating Medicaid and CHIP with the new Exchanges, and applying new Medicaid income eligibility standards established under the law.

In key areas, states will have wide latitude within parameters set by the federal government. For example, states will establish the Exchanges and have substantial flexibility in setting and enforcing the rules that govern them. The federal government would operate an Exchange only in states that do not establish functioning Exchanges that meet federal standards. Moreover, beginning in 2017, states will have the option, through a waiver process, of altering key components of the ACA — including both the mandate that individuals have insurance and the insurance market reforms. In lieu of providing coverage through the Exchanges, states will be able to establish new state health insurance programs for certain individuals and families with incomes too high for Medicaid. And states will have the authority to scale back the Medicaid benefit package for parents and childless adults newly eligible for coverage. States will also have considerable discretion over the extent to which they avail themselves of new opportunities to reshape acute and long-term care delivery systems, integrate care for frail and chronically ill populations, and promote better value in their delivery systems.

States will have significant responsibility to develop the mechanisms for deciding how people apply for coverage and are determined eligible for Medicaid, CHIP, or premium tax credits in the Exchange, and for coordinating all three programs. These changes – and whether they are done well – will have a significant impact on how consumers experience the new law.

Robust advocacy at the state level, supported by national advocacy groups, will be essential. State advocacy groups, with voices that are trusted locally, will be critical.

Because states have so much authority under the ACA, the success of implementation will depend on the policy choices each state makes and on its willingness to devote sufficient financial resources and staffing to implementation. Because of the inevitable variation in states' policy choices and their willingness to provide the necessary resources, state health systems may continue to look very different from one another — and, in some states, very different from what proponents of the ACA envisioned. If the law is implemented poorly in a state, fewer people will enroll in health insurance plans and those with coverage will pay higher premiums and out-of-pocket costs or have less comprehensive benefits than intended. Premiums and costs, particularly for those in poorer health, will continue to rise if various insurance reforms are not implemented vigorously and effectively.

States will need to implement the ACA while facing, over the next two fiscal years, an estimated $235 billion in budget deficits. States may respond to these increased costs by seeking savings measures that could threaten the gains that have been made in recent years in covering children. For example, states may seek to scale back benefits or reduce provider reimbursement rates in Medicaid or CHIP.[12] In short, states will need to gear-up for implementation in a fluid political environment and at a time when resources are very constrained.

At the same time, federal decisions on a vast array of ACA issues will heavily influence states' ability to successfully implement the law. The federal government will promulgate countless regulations and policies related to key aspects of the law. In many cases, these federal rules will set requirements with which states will have to comply. In other cases, the federal rules will set minimum requirements and standards that will establish the parameters for state action, while states will pass their own individual legislation that reflect their choices within those parameters. These federal policy decisions will define the options available to states in a number of areas that will be crucial in determining whether their implementation of the ACA is successful.

Because so many key implementation decisions and tasks will be left to the states, state advocacy groups will be pivotal in helping to ensure successful implementation of the ACA. Robust advocacy at the state level, supported by national advocacy groups, will be essential. State advocacy groups, with voices that are trusted locally, will be critical. Some of the things they will need to do include:

- Developing effective coalitions and strategies designed to ensure that the ACA is implemented properly and to avert short term cuts that threaten existing health safety net programs
- Coordinating public education efforts to better inform the public about the benefits of the ACA
- Working in partnership with national groups to analyze policy, advocate for policy positions, and develop strategic communications plans and initiatives to ensure the best decisions are made on implementation issues at the federal and state levels
- Identifying opportunities to form relationships with other stakeholders, such as insurers, across a range of implementation issues, on some of which they will be allies and on others opponents. One key place where insurers and other industry stakeholders share common ground with consumer advocacy groups is maximizing enrollment in health coverage.

At the same time, national organizations will need to:

- Conduct detailed policy analyses of the ACA and the various policy options it includes
- Consult with state and local groups and relevant experts
- Design and assess policy alternatives, organize coalitions to promote the most favorable options, and engage with policymakers in a range of federal administrative agencies

NOTE: Work on federal issues (except insofar as it involves enlisting the help of state advocacy organizations on these matters) lies outside the scope of this paper. However it is as important and consequential as the state advocacy work outlined in this paper, and will also require adequate support.

Section IV: Critical Issues Affecting State Implementation Efforts

For those not familiar with the provisions of ACA, we offer a very brief overview of the major coverage components of the law.[13] This will assist in understanding the implications of the policy discussion that follows. Each of the issues here is discussed in more detail in Appendix A.

The CBO estimates that the ACA will increase the number of Americans with health coverage by 32 million.[14] It will do this in three ways:

- A major expansion of Medicaid eligibility, the federal-state program for low-income people, to include all legal residents of the United States (except adult legal immigrants during their first five years here) earning up to 133 percent of the federal poverty level (FPL)[15]
- A new insurance marketplace — called an Exchange — where legal residents who earn too much to be eligible for Medicaid (or are not eligible for Medicaid) will be able to purchase regulated health insurance, with income-based subsidies for those earning up to 400 percent of the FPL
- Tax credits to help small employers offer coverage to their employees through the health insurance Exchange

The ACA also establishes much more robust regulation of the private health insurance market, which will have a major impact on access to and the cost of coverage, particularly for those in poorer health.

Number of People Newly Eligible for Medicaid and for Subsidies under the ACA, by State

*Urban Institute Analysis of 2007-2008 Current Population Surveys**

State	Number Newly Eligible for Medicaid[16]	Number Eligible for Subsidies[17]
Alabama	430,512	207,000
Alaska	49,996	55,000
Arizona	*59,037*	*454,000*
Arkansas	251,191	198,000
California	2,378,145	2,360,000
Colorado	286,388	275,000
Connecticut	148,560	126,000
Delaware	*7,989*	*40,000*
District of Columbia	32,028	19,000
Florida	1,171,792	1,475,000
Georgia	773,908	524,000
Hawaii	116,666	40,000
Idaho	105,758	106,000
Illinois	797,343	702,000
Indiana	374,080	324,000
Iowa	*5,161*	*109,000*
Kansas	178,900	137,000
Kentucky	425,777	221,000
Louisiana	482,028	312,000
Maine	54,707	72,000
Maryland	301,443	269,000
Massachusetts	*0*	*60,000*
Michigan	468,310	480,000
Minnesota	260,470	187,000
Mississippi	348,341	153,000
Missouri	385,388	324,000
Montana	78,671	72,000
Nebraska	108,553	98,000
Nevada	157,568	152,000
New Hampshire	70,136	65,000
New Jersey	476,277	382,000
New Mexico	182,051	168,000
New York	188,749	970,000
North Carolina	751,886	655,000
North Dakota	32,773	31,000
Ohio	785,249	521,000
Oklahoma	331,935	248,000
Oregon	327,466	241,000
Pennsylvania	637,031	486,000
Rhode Island	58,980	51,000
South Carolina	402,873	336,000
South Dakota	48,607	37,000
Tennessee	365,643	329,000
Texas	2,167,914	2,048,000
Utah	174,702	152,000
Vermont	*0*	*33,000*
Virginia	499,518	399,000
Washington	*411,076*	*336,000*
West Virginia	161,355	107,000
Wisconsin	291,769	220,000
Wyoming	37,613	35,000
Total	**18,642,311**	**17,401,000**

**Population does not include undocumented persons. Simulated as if reforms were fully implemented in 2009. Italicized numbers indicate a sample size less than 50 observations.*

Source: Urban Institute, How Would States Be Affected By Health Reform? Timely Analysis of Immediate Health Policy Issues, Holahan and Blumberg, January 2010

www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf

These coverage provisions, far-reaching though they may be, are only part of the law. In fact, the ACA will affect most aspects of the nation's health care system, including health care delivery systems, Medicare, long-term services and supports, prevention measures, the health care workforce, and health care cost containment among other issues.

The ACA will affect most aspects of the nation's health care system, including health care delivery systems, Medicare, long-term services and supports, prevention measures, the health care workforce, and health care cost containment.

While the promise of the law is great, the latitude given to the federal and state governments in implementation means that how the law is implemented will have a powerful impact on:

- how many of the uninsured actually get coverage, which could be significantly more or less by 2019 than the 32 million estimated[18]
- whether the coverage will be comprehensive or will still leave out many services that are key to maintaining health and curing or treating sickness
- whether the coverage is affordable, when taking into consideration both the premiums people pay and the out-of-pocket costs they incur
- whether individuals who are sicker can access affordable care or continue to face higher, unaffordable premiums because of insurance company "cherry picking" of healthier enrollees
- whether measures aimed at controlling costs do so in ways that promote or adversely impact the quality of care
- whether the underlying health of the population is improved and racial and ethnic disparities in health care and health are reduced

While there are thousands of detailed issues that must be resolved at the federal and state levels in order to implement the ACA, a number of issues are of particular importance to low and moderate income families and communities of color (who make up the bulk of the uninsured and are expected to constitute about half of those becoming newly eligible for Medicaid or subsidies[19]), and people with chronic illnesses and other at-risk populations (who have often been excluded from coverage in the individual insurance market). The following section presents an overview of these issues and describes why they are important. We address both critical issues over which states will have discretion and federal issues that will shape the key aspects of implementation of the ACA in the states. Finally, while recognizing that current prospects for legislative improvement to the ACA over the next couple of years are dim, we identify several key areas where we believe improvements are necessary and where it may make sense to begin laying the groundwork for future changes. A much more detailed exposition of these issues is provided in Appendix A.

Critical State and Federal Issues

Medicaid and CHIP — including determining the level of benefits provided to newly eligible people; modifying existing eligibility and enrollment practices to conform to the new requirements of the ACA; and coordinating Medicaid and CHIP with the subsidies that will be provided through the Exchanges, so that people can easily enroll (and remain enrolled) in these programs and move between Medicaid and the Exchange as

their income and other circumstances change without "falling through the cracks" or experiencing gaps in coverage. These issues are critical to the ACA's success. Extensive research and years of experience with Medicaid and CHIP show that if the application process is difficult and complex, if states require extraneous information or extensive paper documentation, or if state processes are cumbersome, fewer people will get health coverage.

Insurance Reform and Exchanges — including the governance, structure, financing and functions of the Exchanges; the regulation of plans both within and outside of the Exchanges to promote quality, affordability and transparency; and efforts to minimize opportunities for insurance companies either to avoid covering patients who require more expensive care or to seek to cover healthier people *outside* the Exchanges.

Health Equity — including ensuring the development and implementation of national quality and national prevention strategies to reduce racial and ethnic health disparities and to promote health equity, such as programs to enhance data collection, improve community prevention initiatives, target delivery system improvements and educate health professionals on cultural competency and disparities.

Consumer Assistance — including creating a robust system of consumer assistance and support to help consumers navigate the new system and obtain coverage and subsidies for which they are eligible, and to help identify and resolve implementation problems.

Health Care Workforce and Capacity — including addressing the shortage of primary care providers and certain specialty services (such as dentistry), particularly for low-income populations in underserved areas, and expanding community health centers.

Community Transformation Grants — including implementing a new program of grants designed to improve community health, reduce chronic diseases, reduce health disparities, and promote evidence-based prevention methods.

Public Health Infrastructure — including strengthening core public health functions to reduce disease incidence, promote long-term cost containment, and enhance the capacity and effectiveness of state and local public health departments.

Delivery System and Payment Reform — including development of clinical models supported by appropriate reimbursement models designed to reduce preventable hospitalizations and institutionalizations, as well as the overuse of ineffective treatments or procedures.

Premium Tax Credits and Reductions in Cost-sharing — including determining the rules relating to accessing tax-credit subsidies for the purchase of insurance in the Exchanges, reconciling subsidies received against actual income at the end of the year, and assuring that low-income people can enroll in plans with lower cost sharing.

Employer and Individual Responsibility — including determining eligibility for subsidies through the Exchanges for workers who face high premiums relative to their income for coverage through their employment and encouraging employers to provide affordable coverage to their workers.

Charity Care and Community Benefits — including implementation of new rules related to hospitals' provision of charity care and billing and collections for the uninsured and under-insured, as well as requirements that hospitals partner with their communities in developing programs to address community needs.

State Waivers and Innovations — including decisions about whether to make use of options for states to exempt themselves from many of the provisions of the law, such as running the Exchanges (and allowing the federal government to take on this role), and designing innovative programs, such as creation of integrated health delivery systems or inclusion of a public option in their Exchange.

Basic Health Plan — including consideration of a state option to create a state-administered Basic Health Plan for people with incomes between 133 percent and 200 percent of FPL, rather than allowing them to purchase subsidized coverage in the Exchanges. This approach has the potential either to improve access and quality of care or to hinder access and weaken the Exchanges, depending on how it is designed and administered.

State Administration — strengthening state administrative capacity to take on the substantial new responsibilities that states will incur, such as establishing the Exchanges, expanding and restructuring Medicaid, administering new public health programs, and implementing new regulations. This issue is intimately connected to the question of whether states allocate adequate funding for these tasks.

Legislative Improvements to the ACA — including improving the affordability of subsidies, reducing cost-sharing, removing the five-year bar on Medicaid coverage for some legal immigrants, enabling undocumented immigrants access to the Exchange, temporarily increasing payments to Medicaid primary care physicians, and ensuring access to family planning services.

Section V: A Strategy for Successful State Implementation of the ACA

Kaiser Family Foundation President Drew Altman, in his April "Pulling it Together" column, provides an overview of the implementation of the ACA:

> *Now that historic health reform legislation is law, everyone is rightfully focused on implementation. There are two very different ways to look at implementation. One is the more legalistic worm's eye view, which sees implementation largely as the process of putting into effect what was written in the law. In the worm's eye view implementation proceeds in a linear fashion from legislation, to regulations specifying what the statute calls for in greater detail, to operations in the field.*
>
> *The other perspective on implementation is the bird's eye view. It sees implementation as adaptive and somewhat unpredictable; a function of real world developments, politics, the number of players and decision points and the time period involved in implementing a law. In the case of health reform, implementation would depend not only on what is written in the law, but also on how the political and economic landscape shifts, how governors and states respond to health reform, how the private sector responds, how health care institutions and health professionals filter the intent of the legislation on the front lines, what the media does, and most of all, what the public's reaction to health reform is over the next several years.*[20]

In this section we propose a strategy for achieving the most effective state implementation of federal health reform, taking into account both the "worm's eye" and "bird's eye" view of implementation. The strategy has three major components:

1. Building support for the ACA and countering efforts to undermine it
2. Creating sufficient state capacity and infrastructure to support implementation of the ACA
3. Creating coordinated and integrated national and state structures to support state implementation work

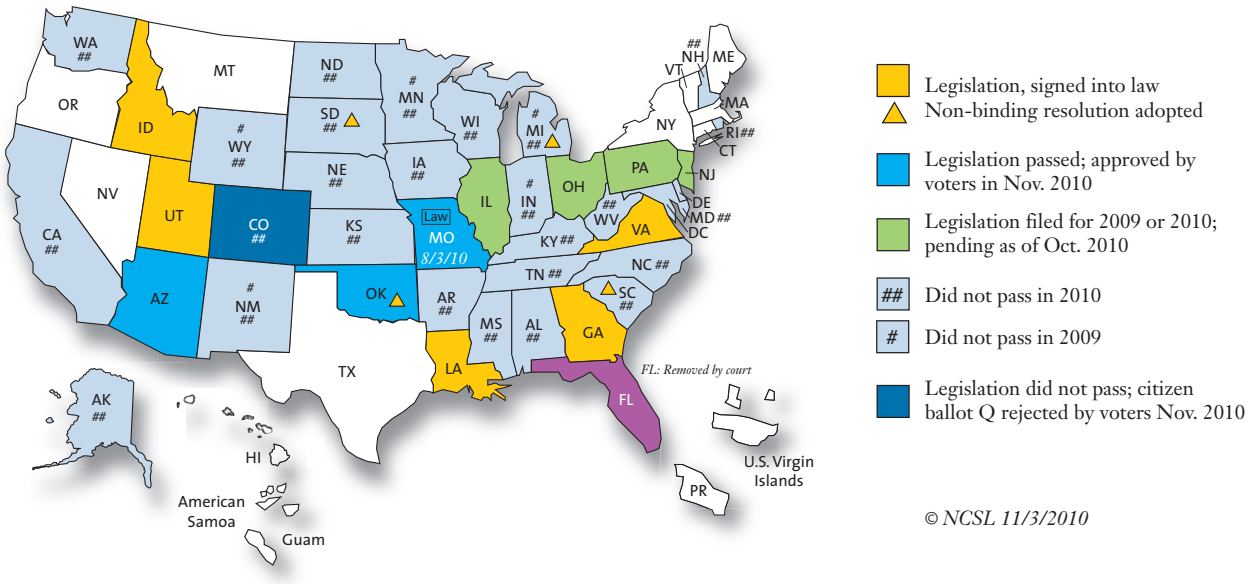
NOTE: In the following sections we use the term "state partners" primarily to refer to state policy, advocacy and constituency organizations. However, much of the support referred to here will also be of assistance to other groups and individuals who are supportive of the ACA, such as Governors and state administrative officials who are responsible for implementing the law, state legislators, provider groups, and other stakeholders.

1. Building Support for the ACA and Countering Efforts to Undermine It

When it comes to the "bird's eye view" of implementation, the adage "a rising tide lifts all boats" is apt. Creating the best possible overall climate nationally and in each state for the ACA is a critical component of the strategy.

An early example of how the political environment shapes state actors is the movement to challenge the legality of the ACA. States' decisions about whether to take legal action to block the ACA were made largely on party lines, motivated by a mix of ideology, party politics, and a desire to appeal to public opinion. In Indiana, Gov. Mitch Daniels used a misleading study to claim that the Medicaid expansion that is a major piece of the ACA will devastate his state's budget.[21] In Missouri, the Legislature placed an opt-out of the individual mandate on the August primary ballot that was recently approved by a substantial margin. Countering such attacks is important in preventing the erosion of support for the ACA.

40 States with 2009-2010 Legislation Opposing Certain Health Reforms



40 States with 2009-2010 Legislation Opposing Certain Health Reforms

FLORIDA NOTE: The proposed ballot question was removed from the ballot by the state court on August 31.

Policymakers pay attention to national and state public opinion polls. Already some national polling found diminished enthusiasm for repeal efforts, leading some opponents to soften their repeal rhetoric. State polls, like one in California taken soon after the law passed, found the ACA to be popular and bolstered political will in the state to implement the law.[22]

Improving the overall public climate for the ACA is one key to successful implementation. Fairer winds will make easier sailing in discussions of all of the specific policy decisions that need to be made. Myriad actions are needed to help accomplish this goal. To improve the general climate for implementation, we need to undertake the following:

Public education: Although recent polls suggest some improvement in public support for the law, an urgent need to increase public understanding of its key elements remains. As a Kaiser Family Foundation poll in April of this year found, "… 55 percent say they are confused about the law and more than half (56 percent) say they don't yet have enough information to understand how it will affect them personally."[23]

Public education efforts should focus on informing people about how the law will affect them and dispelling myths about how it may harm them. Public education should include communication directed at targeted constituencies and education of the broader public through traditional, new and paid media. Given the intensely partisan nature of the struggle for passage of the law, it will be necessary to de-politicize public education efforts in order to broaden support for the ACA. At the same time, some communication efforts will need to help the public understand that the law does seek to change the status quo and in doing so may take on entrenched interests. These different approaches to public education are complementary but may need to be pursued by distinct messengers in order for each to be effective.

Message development, dissemination and training: In this time of information overload, it is critical for supporters of the ACA to align communication frames and messages nationally; only consistent and persistent delivery of key pro-implementation messages by a range of effective spokespeople is likely to break through the clutter. Communication frames must be based on research that tests the views and responses to messages among national and state audiences and a variety of constituencies, and this research must be translated into a variety of forms, including talking points, campaign communication plans, editorials and letters to the editor, and so on. To be effective, they must take into account the messages that people will hear from opponents of the ACA, be tailored to local audiences, and delivered by trusted messengers. It will be important to organize constituencies helped by the ACA, such as young adults or people with pre-existing conditions, to be messengers. Training materials on communications frames and messages must be developed and disseminated and formal training provided.

National and state issue and education campaigns: Campaigns are prolonged strategic efforts that aim to shape public attitudes and change public policy. They go beyond issue advocacy or public education by having a strategic arc, greater breadth, and a highly-developed communications component. Shaping public opinion around the ACA will require national campaigns in which state partners participate – campaigns designed to be run in a coordinated fashion in multiple states – and similar campaigns run separately in individual states. One example of a key issue that needs to be addressed by a sophisticated campaign is the effort to nullify portions of the ACA.

State constitutional and statutory amendments to nullify the mandate that people have health insurance qualified for the ballot in four states in 2010. ACA opponents will portray passage as a popular mandate to halt implementation in their state, and more nullification initiatives are likely to be debated in state legislatures and placed on state ballots in 2011 and 2012. Even if nullification efforts ultimately are found to have no legal standing, they create a negative climate for implementation.

Opponents of the ACA who are advocating for nullification measures have begun developing state-level campaigns. They are hiring campaign consultants, launching websites and engaging social media. Campaigns to *defeat* nullification measures will require a similar or greater level of effort. Those seeking to prevent nullification will need to engage in polling, do opposition research, develop messaging, conduct aggressive voter education, mobilize supporters, and develop the capacity to respond rapidly to opposition attacks on the ACA through earned and paid media. Strategies at both national and state levels will need to be initiated and resourced.

At the national level, organizations that have affiliates and contacts in states will need to monitor state legislation and ballot initiative petitions, coordinate legal strategies, develop consistent messages and media strategies, share outreach and education strategies, and identify policy and public opinion research needs. In states where this debate is occurring, key advocates, influential membership groups and fiscal policy research organizations will need to come together to respond. Strategies will vary from state to state, but some necessary components include volunteer and advocate trainings, speakers bureaus, collection of endorsements, direct advocacy with legislators, and intensive media outreach. While the coalitions will focus on public education, in states where initiatives are actually placed on the ballot, they may also need to engage in voter mobilization drives.

Rapid response capacity to refute attacks on the ACA: One essential component of campaigns is the ability to respond quickly to attacks and false assertions. Opponents of the ACA at both the federal and state levels will continue to issue false or misleading criticisms of the law. Rebutting these criticisms through analysis combined with coordinated communications efforts targeted at policymakers, opinion leaders, and traditional and social media, will be critical in weakening the opposition and creating an environment more conducive to successful state implementation of the ACA.

Today's media environment is characterized by the 24/7 news cycle and an ever-growing number of influential outlets — including cable television, talk radio, newspapers, blogs, Facebook and Twitter. In this environment, one does not have the luxury of responding in a leisurely fashion to attacks and misleading claims. Moreover, when attacks are orchestrated across the full spectrum of outlets cited above, responses cannot be limited to a single venue. Even when claims do not get much attention in traditional media (such as newspapers), they often attract enough attention elsewhere (such as cable television and blogs) for key players including policymakers, regulators and stakeholders, to pay real attention.

For these reasons, national and state groups must aggressively seek to identify emerging lines of attack by monitoring traditional and new media at the national, state and local levels, as well as public statements and events organized by anti-reform policymakers and interest groups. Supporters of the ACA must quickly analyze attacks and identify the best response strategy from a menu of options, ranging from immediate media outreach to rapid distribution of talking points and templates for groups to use on the ground.

Building support from policymakers, regulators and stakeholders: Shaping the climate for implementation of the ACA requires influencing key policymakers, regulators and stakeholders not just in terms of specific policy issues, but also more broadly. State partners need to build support through roundtables, public forums, specialized media, and regular communication. They should try to work closely with policymakers, regulators, and others in states that support the ACA, including state commissioners and legislators, and, when possible, strengthen their efforts through collaboration with other stakeholders.

Delivering on "early wins": One of the best ways to reassure the public and build support for the ACA is ensuring that implementation of "early wins" is successful and widely advertised. Some of the "early win" measures include the creation of high risk pools for uninsured people with pre-existing conditions, modest insurance reforms aimed at addressing some of the most egregious practices of the insurance industry, improvements in Medicare benefits, better access to financial assistance from hospitals, creation and expansion of community health centers, new public health investments, and mechanisms for informing people about existing health care options such as the new healthcare.gov website. In addition to delivering on these early wins, it will be important to keep the existing Medicaid and CHIP programs strong and continue efforts to enroll eligible children (and others, when applicable) into the Medicaid and CHIP programs.

2. Strengthening State Implementation Infrastructure and Capacity

As implementation proceeds, state advocates and policymakers need to attend to both the "bird's eye view" of the ACA (the public climate) and the "worm's eye view" (specific regulations and legislative issues). They will be operating in an environment in which state resources are scarce while health industry stakeholders have significant resources and political clout. To compete in this environment, state partners must both enhance existing capacities and develop robust new ones. In addition, they need to build upon existing working groups or establish new ones — or create other appropriate mechanisms — to develop strategies and coordinate implementation work in their state.

State partners must both enhance existing capacities and develop robust new ones. Significant investment in state advocacy capacity is needed in states with well-established infrastructures and in those that are starting from scratch.

Building state capacity: Advocacy capacity varies widely across the states, but state-based advocacy organizations working on a variety of health care, health disparities and public health issues operate in the large majority of states (easily more than 30). State fiscal policy organizations, which work closely with health advocates, also work on state budget and tax policies in more than 30 states.

In recent years, a sustained effort has increased the capacities of leadership organizations and created systems of advocacy comprised of organizations that represent many different constituencies and possess a variety of specialized skills. In turn, these networks have developed working relationships with other health sector stakeholders and with policymakers. Yet, even within these states, there is a wide variation in the depth of capacity, and a number of states have very little developed state health advocacy capacity. These tend to be states that are generally hostile to reforms that benefit low-income people and communities of color and lack strong infrastructures to support any programs or initiatives that benefit consumers, low-income communities, or communities of color.

Significant investment in state advocacy capacity is needed both in states with well-established infrastructures and in those that are starting almost from scratch. Maintaining current levels of support is critical to sustaining core capacities. Additional resources will be essential to expand advocacy activity to more states, build new expertise and capacities, and handle the large increase in the volume of work. This is particularly true because many state-level partners are already overwhelmed by ongoing state budget battles. State partner organizations must have the following capacities:

Policy analysis and advocacy: The ability to conduct research; analyze complex legal, fiscal, and health policy issues; develop policy options; and conduct legislative, administrative and grassroots advocacy based on this work is critical to successful state implementation efforts. These capacities allow advocacy groups to:

- ensure that the consumer voice is represented in key decision making arenas
- develop relationships with key legislative and administrative policy makers
- lay out the policy options that states will have to choose from, and educate a broad range of audiences, including policymakers, other advocacy organizations, stakeholders, and consumers about these options

- develop policy recommendations that can be effective in enhancing access to health care *and* providing a foundation for mobilizing key constituencies and building alliances with stakeholders
- provide data, facts, and analyses that build a strong case for these specific policy recommendations

Advocates will need to serve as a credible source of solid policy analysis and workable policy solutions designed to address the needs of consumers.

ACA implementation will occur in a complex arena. Within states, policies will be made across a range of agencies. Important interactions among federal, state, and local health and fiscal policies will often need to be understood. Advocates will need to serve as a credible source of solid policy analysis and workable policy solutions that are designed to address the needs of consumers.

One aspect of policy analysis is the ability to produce credible reports and other research that highlight the need for aggressive implementation of the ACA; document its effectiveness; and provide data and analysis to back up implementation choices being pursued. For some policymakers and media elites, data and solid research are key components of successfully making a case for certain policy outcomes. One or more organizations within a state-based advocacy coalition must have this expertise.

To be effective in a policymaking environment where well-funded interest groups can ensure that their preferences are heard, state advocates must be able to operate in a variety of environments, including public debates, legislative battles, and behind-the-scenes communications with state policymakers and administrators. They will need to work with policymakers in both the legislative and executive branches, as well as with state officials responsible for administering the Exchanges, implementing insurance reforms, and administering Medicaid and CHIP programs.

Once state laws implementing the ACA are enacted and work enters the implementation phase, it will be especially critical for state-based organizations to have strong, established relationships with state officials and be able to engage in the details of ensuring that the ACA works for people on a day-to-day basis.

Legal research and analysis: Legal research and analysis is important in identifying legal challenges that have the potential to harm access to health care, as well as legal initiatives that may improve access. The courts have served as an arena for consumer advocacy in several states, and litigation has been an important tool for protecting or advancing consumer interests.

Capacity in this area will be particularly important in implementing the ACA because federal and state rules will need to be integrated and coordinated, and advocates will need to ensure that new state laws and regulations comply with federal requirements while still maintaining existing protections. Legal analysis is also needed to identify the options that are allowable under the law and any federal guidance and regulations that are issued. It is not uncommon for state officials and others to cite legal barriers to adopting improvements. In the absence of credible legal expertise to challenge these assertions, state-based advocacy organizations may be unable to pursue a range of promising opportunities.

The most effective coalitions are marked by strong personal and organizational relationships, and connections that have been built and strengthened through past collaboration.

Coalition building: Strong coalitions are a driving force in many successful statewide consumer health advocacy initiatives. Some strong, broad-based, consumer health advocacy coalitions bring together large numbers of different organizations and stakeholders in coordinated campaigns to achieve common policy goals. The most effective of these coalitions are marked by strong personal and organizational relationships and connections that have been built and strengthened through past collaborative work. A core group may include grassroots organizations, state advocacy organizations and legal services groups. Other coalitions focus on a subset of issues and include not only other advocacy organizations but also stakeholder allies in the health care system, such as hospitals, unions, tobacco control organizations, physician groups, and health organizations such as the American Cancer Society, the American Heart Association, and public health advocacy groups. Each of these types of coalitions plays different roles, but all contribute to achieving success.

Building alliances with less traditional allies such as insurers and providers on issues where industry stakeholder interests align with consumer interests (for example, outreach initiatives and eligibility and enrollment simplification) is also important. A broader alliance can be a key strategy for enhancing consumer success on specific issues. However, the scope of the common issues must be carefully defined and the goals for these alliances clearly articulated. It is important that the members of these less traditional alliances acknowledge that although they have come together to advocate for certain policies, they will likely disagree on other issues.

Grassroots and netroots organizing: Grassroots organizing engages people at the local level, which is where uninsured and underserved people are most likely to experience the effects of health system breakdown. It is in their own communities that health consumers are rejected for coverage, cannot find a doctor who accepts Medicaid reimbursement, wait months for a medical appointment, and are sued by hospitals when they cannot pay a bill. When grassroots organizations are both knowledgeable about health issues and connected to statewide advocacy groups, they play an important role in broader health advocacy efforts. For example, grassroots organizations can:

- build a base of popular support for the ACA among people who are directly affected by policy decisions, including people of color, the uninsured, underinsured and others disproportionately affected by disparities in access to health care
- put a human face on the need for better health care access and demonstrate popular support for change
- influence key local and regional decision-makers
- ensure that state health advocacy addresses the needs of people who use the health care system

Communications: The ability to use media and communications is essential to building timely public and political support for the ACA and countering opposing arguments. Communications and media strategies are particularly important in places where interest groups are conducting well-funded media campaigns opposing the ACA.

Advocates will need to "translate" policy analyses and research so it is accessible to consumers and other stakeholders affected by the policies.

Advocates will need to ensure that they are appropriately "translating" policy analysis and research so it is accessible to consumers and other stakeholders affected by the policies, the broader public, and legislators and other decision makers who may not understand the nuances of complex policy issues. Accessible research and policy analyses play an important role in connecting grassroots organizing and statewide policy advocacy.

Media and communications capacities contribute to advocacy success by:

- effectively framing issues for the public-at-large and for particular audiences, including through use of individual stories to make issues understandable to a broad audience
- describing problems in ways that are accessible to grassroots and constituency organizations and create public and political demand for solutions
- making a strong public case for policy change and critiquing opposition positions
- getting the right data and information to legislators, policymakers and stakeholders at the right time
- responding quickly and effectively to attacks on the ACA by opponents
- educating media about policy issues, building broad editorial and op-ed support, and obtaining media coverage at critical junctures
- developing electronic mechanisms and other communications strategies for conveying timely information to grassroots organizations, advocacy organizations and other supporters

Strategic campaign development: Moving a health policy agenda forward or defending an existing program often requires an organized campaign. The ability to plan and coordinate advocacy campaigns is particularly important in states where interest groups that have a large financial stake in policy decisions fund sophisticated lobbying and media efforts. To counter these efforts, consumer health advocates must be able to:

- identify inside decision makers who can become champions for the desired policy outcome
- build and maintain alliances to expand support for and reduce opposition to the policy
- orchestrate the involvement of campaign partners and allies so they do the right thing at the right time in the decision-making processes
- closely track the policy process for opportunities for intervention and then move quickly to take advantage of them

Fundraising: A critical capacity for any organization is the ability to raise resources to carry out its mission. The funding environment differs dramatically among states, although in most places foundations represent the most important source of funding for consumer advocacy.

Monitoring and feedback: Organizations must be able to capture the on-the-ground experiences of consumers who are enrolling in coverage programs and accessing care.

This knowledge can be used to identify the need for further policy improvements. Consumer assistance programs operated by advocacy and community-based organizations provide an excellent way to both enhance access to care for vulnerable populations and to monitor the overall impact of policy and implementation efforts in real time.

Creating state implementation working groups: One step in developing adequate infrastructure in each state to support ACA implementation is the creation of a consumer implementation working group or some other comparable mechanism. Such a group would bring together a variety of state partner organizations, including health care and low-income advocacy groups; state fiscal policy groups; children's advocacy organizations; multi-issue grassroots organizations and networks; faith groups; labor unions; the public health and prevention community; and groups representing communities of color, seniors, women and people with disabilities and chronic health conditions to discuss and exchange information about the overall implementation effort in a state.

The goals for each working group could include:

- educating organizations about key policy priorities and needed advocacy efforts
- coordinating communications and public education strategies, including messaging
- sharing information about state and national issue campaigns that groups are undertaking, including legislative efforts
- developing relationships and ongoing communication with key state policymakers
- developing state implementation campaigns that include multiple participants

In some states, the implementation working group may be in addition to and separate from other, narrower coalitions that focus on specific policy issues such as Medicaid expansion, coverage for children, immigrant access to health care, or coverage for reproductive health. These narrower coalitions may include a subset of organizations from the implementation working group. They may also include other stakeholders, such as certain health care providers, who are allies on a particular issue but are not part of the implementation working group. A stakeholder coalition working to maximize enrollment may be broader still, including many different "industry" groups who may ally only on that issue.

3. Creating Coordinated National and State Structures

The joint federal/state structure of the ACA requires a high level of coordination between federal and state implementation efforts. As discussed previously, decisions made at the federal level will have a major impact on state implementation efforts, while decisions made at the state level will be key in determining whether the federal law is effective. In this environment, structures that support the coordination of national and state implementation efforts are essential.

Coordination efforts need to reflect the two-way nature of the relationship — that is, that federal implementation policy strongly affects states, while experience from state-level efforts can inform federal action. Many national organizations, including those in the Planning Group, have a long history of and highly developed capacity for providing a wide variety of technical assistance to state organizations and policymakers. Many of

these groups are now engaged in addressing federal regulatory and legislative issues that are critical to the success of the ACA and implementation in the states. At the same time, it is important to recognize that many state partners were actively involved in supporting passage of the ACA, and their experience with state level work on Medicaid enrollment, insurance regulation and other issues has informed and will continue to inform national organizations and be relevant to other states.

The complexity and increased responsibility that the ACA places on states requires an even greater effort by state and national organizations to work together.

The complexity and increased responsibility the ACA places on states requires an even greater effort by state and national organizations to work together and to engage in advocacy at both the state and federal levels. And, in fact, both state and national organizations are already undertaking collaborative efforts. State groups are working to collaborate among themselves and with national organizations. National organizations are involved in intensive discussions with one another, and some national groups with similar policy priorities or missions are working to establish an effective division of labor. Some of these efforts are well established; others are emerging. Any new coordination efforts need to build upon existing infrastructure and take advantage of existing collaborations. See Appendix B for existing coordination efforts among national organizations.

One challenge of implementation of the ACA is that coordination and communications need to go in multiple directions: between state and national advocates, from national to state advocates, and from supporters working inside of federal and state agencies to advocates outside of government. Because the locus of most coordination efforts is in Washington D.C., it is important to ensure that the policy and political experience of state advocates is recognized and brought to bear on communications and strategy planning. Coordination among national organizations and between state and national organizations is needed to:

- expand sharing of information, strategies and outcomes across states and support the participation of state advocates in federal policy discussions
- develop common advocacy approaches within specific policy areas (such as insurance reform)
- develop common messaging and communications strategies
- identify best (and best possible) policy and strategy approaches and adapt them to different state environments
- align policy and strategic advice
- ensure that discussions are occurring across issue silos

We propose the following "functional" view of coordination.

NOTE: inclusion of a function on this list does not imply that efforts in this area are not already occurring.

Coordination in specific issue areas: Forums for coordinating policy and advocacy activities have quickly emerged; they include advocacy efforts at the federal level in specific issue areas. Some of these efforts build on existing forums; others are new. We believe that this approach makes sense, and recommend that policy and advocacy work

on major issue areas be coordinated through specific work groups for each area. In some cases, these groups will need to facilitate additional state participation in their discussions, as constant attention to bringing state partners into the Beltway conversation is necessary.

Coordination of specific capacities or projects: As within issue areas, groups are emerging to coordinate activities or approaches in specific types of capacities (such as messaging and rapid response to opposition attacks) or specific types of projects (such as ballot initiatives and town hall meetings). These groups have emerged as needs were identified and organizations volunteered to work together, sometimes under the leadership of one or more organizations. We believe that this practice is also sensible and again emphasize the importance of communicating with state partners and involving relevant state advocates in these efforts.

Identification of gaps and unmet needs: The complexity of implementation requires an overview of all the moving parts and the ability to identify areas that are not being sufficiently addressed. It is essential that advocates take advantage of all key opportunities to promote the ACA. It is also important that federal agencies responsible for the ACA receive regular communication, research or other supports that can assist them in implementing the law. When a gap or need is identified, the various groups that are engaged in that area need to develop a strategy to fill that gap. A key goal of the Federal-State Implementation Project is to perform these functions.

Mapping and dialogue on overall implementation work: Again, because of the complexity of the implementation effort, it would be helpful to have a mechanism for mapping and promoting dialogue and cooperation across the spectrum of groups working on implementation. For example, groups at the national and state levels might be unaware of ongoing activities in which they might like to participate or from which they could benefit. Groups sometimes are interested in an issue but don't know where to get information about it. And, in general, groups can often benefit from knowing what other groups are doing.

Coordination could be promoted through the creation of tools such as: 1) a calendar of implementation activities; 2) a listing of the goals and contact information for the various implementation groups; 3) a blog or a password-protected website that posts the work of the various implementation groups; and 4) a forum (perhaps "virtual" with occasional in-person meetings) through which key participants in the various implementation groups could share information and identify common needs, barriers and opportunities. At this point, no specific mechanism exists to carry out these functions, although some groups are already talking about coordinating activities across policy areas. We recommend experimenting with some of the approaches suggested above to see which are most effective in filling this gap.

Coordination of interactions with state partners: Coordination among national groups to align their communication, policy and strategic advice on issues and to clarify which organizations are taking the lead on which issues, would be enormously helpful to state partners. Such coordination would mean that state partners would be more likely to receive support and advice that takes into account the views of a range of national partners, and they would be less likely to receive conflicting advice or get multiple requests to engage in similar actions. It would also be helpful if national groups were mindful of the variety of demands made on state groups across issue areas, and not just within a single issue area, and of the fact that state advocates often operate with limited resources in a confined regulatory and legislative space.

Many ad hoc activities to support national and state partner collaboration are already in place through existing networks of state partners, including regular calls with and convenings of representatives of state groups. Several Planning Group members are making a concerted effort to coordinate their policy and advocacy assistance to state organizations, including consulting with state groups on the design of meetings and materials. However, as with the mapping function, a single mechanism responsible for carrying out this function does not exist. Additional work is likely to be needed to develop effective approaches for assuring that national policy and advocacy advice is aligned to the fullest extent possible, that state-level expertise is shared across states, and that state partners participate fully in strategic discussions and decisions.

Ensuring Federal Regulations and Policies Facilitate Successful State Implementation

National and state organizations will need to conduct significant policy advocacy work with federal policymakers to ensure the right rules and regulations, and policy options, are in place for states. This will entail intensive policy and legal analysis, the development of policy options, and extensive work with both Administration officials *and* career staff in a number of agencies (career officials often define the choices for the Administration policy officials).

National organizations will need to conduct significant policy advocacy work with federal policymakers to ensure the right rules, regulations and policy options are in place for states.

Many interest groups, including some very powerful ones, are deeply involved in trying to influence these federal policies. So, it will be important for state coalitions to weigh in, working with the national groups. This will be true with respect to comments on federal regulations and various other federal policy decisions. It also will entail some work by state groups with their Congressional delegations to push Administration policymakers in certain directions. State coalitions will need both to seek improvements in certain federal policy proposals and to defend other proposals that are beneficial but are coming under attack from powerful interests.

Federal policies will be implemented in states that have varying characteristics. State groups will need to evaluate federal policy options to see if they will work in their states and to offer recommendations for improvements, as well as alternative federal solutions that are likely to be more viable at the state level. State groups can anticipate some consequences of federal policy decisions that national groups may miss.

A number of state groups are particularly well-placed to offer comments on federal rules and guidance that will inform the policymaking process. For example, some states have already instituted relatively robust insurance reforms or have substantially expanded Medicaid, and their experience can provide useful lessons to federal policymakers (and national groups).

Finally, as the ACA is implemented, having feedback from state groups as to how various federal policies are working will be important in making mid-course corrections in federal regulations and policy guidance.

Needless to say, national organizations will need to work closely with state groups on these matters.

State Investment Strategies: Options, Pros and Cons

This section briefly lays out several possible guiding strategies for investment in state implementation efforts and touches on the pros and cons of each. Settling on a single approach is difficult for two reasons. One is the diversity of funder interests and priorities. The other is the nature of ACA itself, with its broad substantive reach and devolution of much decision making to the states, thus creating a need for 51 implementation campaigns.

The list of strategies outlined below is not exhaustive; rather, it incorporates suggestions that have come from Planning Group members. These strategies focus on targeting investment based on various types of state environments. Additional targeting based on demographic groups (for example, seniors or racial and ethnic minority communities) or issue areas (for example, delivery reform or enrollment policy) is compatible with all of the options we present here. Certain options (such as targeting investment based on electoral or lobbying considerations) are not considered, as they are inappropriate for most of the funders at the table.

Positive pathbreaker: One strategy would be to invest in those states most likely to positively and robustly implement the ACA. The advantage of this approach is that successful implementation in one state could provide lessons for other states. It also has the potential to create momentum for further federal intervention in states that are struggling to implement the law, to bring them up to the level of states that have been successful.

The limitation of this approach is that it ignores large swaths of the country and bypasses entirely places that may have the greatest need. There is also a risk of too narrowly defining what it means to be a positive pathbreaker. For example, Illinois is a leader in public program expansion but not in delivery reform or private insurance regulation, while Louisiana and North Carolina have been leaders in enrollment system innovations and delivery reform respectively, even though they lag behind in many other areas.

Negative pathbreaker: Another option would be to target investments where there is the greatest likelihood the ACA will be implemented poorly or where efforts to repeal or undermine the ACA are strong. This strategy would aim at moderating the worst outcomes in the short run and over the longer term building a more robust advocacy system. Its principal drawback is that in some negative pathbreaker states, it may not be possible in the short run to gain enough influence to make a significant difference.

Strong advocacy capacity or local funder partners: An approach that could maximize national funders' return on investment would use two criteria to target funding: focusing on states that 1) have strong consumer advocacy capacity; or 2) local funders willing to match national investments. Some very strong consumer state advocacy organizations and networks exist in states that do not have significant local funder resources. In other states that do have local funders, state funding resources might foster the development of a stronger consumer advocacy capacity. These criteria, singly or in combination, would encompass a broader range of environments than a focus on positive pathbreaker states, as strong advocacy groups and local funding partners are not found exclusively in the most progressive states. This strategy shares the limitation of skipping over places where need is highest.

High need: Going where the need is greatest — states with the highest proportion of uninsured, greatest racial and ethnic health disparities, greatest need to build consumer infrastructure — has obvious appeal. Approaches that skip over states with challenging environments and few internal resources consign them to poor outcomes, and leaves opposition to the ACA in these states unchallenged. Focusing on states with high need would respond to these problems. However, as with negative pathbreaker states (often the same states), the time horizon for success is longer, with more modest successes or even failure likely in the short run.

One possible way to mitigate this risk is to identify local investment targets in these states, which could help build a base for a later statewide effort. The ACA offers a number of opportunities for local organizing, for example the Community Transformation Grants program or hospital financial assistance and community benefit policies. Virtually any state, even the most challenging, has some localities where consumer advocacy could gain a foothold.

High impact: Not all states are equal in terms of the contribution that successful implementation could make to overall national success. For example, more than half of the entire uninsured population in the country lives in the ten states with the highest number of uninsured.[24] The high impact states are also regionally diverse. A disadvantage of this approach is that measuring impact based on a single metric, such as the number of uninsured, may skip over aspects of the law that address other issues, such as delivery reform or public health investment. Also, as the major impact of Massachusetts' health reform demonstrates, the size of a state is not necessarily indicative of the ripple effect implementation in that state can have.

Mixed approach: The best approach would take into account these various considerations by selecting a cross-section of states with varying attributes — most likely by funding some pathbreaker, some high need and some high impact states. This approach should address both environmental and geographic diversity. Geographic diversity is advantageous because lessons learned in one state are often more easily transferred to neighboring states. It is possible to combine this mixed approach, with a focus on pathbreaker, high need, and high impact states, with attention to advocacy capacity and the presence of local funders in states. However, making these latter two criteria an absolute condition for funding would result in completely writing off some parts of the country.

The best approach would select a cross-section of states with varying attributes — some pathbreaker, some high-need and some high-impact states.

A mixed approach has the advantage that funding can be customized to suit funder interests and preferences, but the drawback of offering less specific guidance to any individual funder.

Section VI: Required Resources

State Organizations

Over the past decade, a number of national organizations and funders have recognized the value of effective state advocacy on behalf of health care consumers, especially those with low incomes, and have committed to building a strong state advocacy infrastructure. This has involved not only developing the capacity of individual state organizations, but also facilitating the creation of state-based systems of advocacy that include networks of organizations that work together to improve the health care system.

Often no single organization in a state possesses all of the capacities needed for successful advocacy, but by collaborating effectively and strengthening their individual components, networks of state organizations can build a system-wide advocacy infrastructure.

Often no single organization in a state possesses all of the capacities needed for successful advocacy, but by collaborating effectively and strengthening their individual components, networks of state organizations can build a system-wide advocacy infrastructure that collectively possesses these capacities.

State advocacy organizations and networks have had a significant impact in many states, both by increasing consumer and community engagement in advocacy and by providing effective analysis and communications work. Advocacy efforts in various states have resulted in the effective defense of Medicaid coverage during tough budget times; expansion and improvement of Medicaid and CHIP in better times; increases in state tax revenues to help finance expansion of health care programs and other services for low-income households, or to protect these programs from threatened cuts; rejection or moderation of ill-advised tax cuts or tax breaks that would weaken state budgets and place health care programs at risk; the institution of delivery system reforms to improve quality and lower the cost of care; passage of consumer protection legislation; stronger oversight and monitoring of the individual and small group insurance market; and the approval of stronger hospital charity care requirements.

State groups also played a crucial role in advocating for the ACA, which led to greater overall capacity and new expertise in working on national health policy issues. In addition, the national reform campaign resulted in the creation of new coalitions and collaborative relationships at the state level and an increase in the number of organizations that now want to work on state-level ACA implementation. These state nonprofit organizations are now positioned to extend efforts to support effective implementation of the ACA in their states, including the critical task of building public understanding and support, if they can secure the necessary resources and technical assistance.

Level of Resources Required for State Groups

The combined investment of funders over the past three years to support building or strengthening core state advocacy capacity has been more than $20 million, spread over at least 34 states.[25] However, most of the current support is scheduled to end in 2011; a significant percentage will end in 2010.

Successful implementation of the ACA will require increased levels of support to address the broad range of issues. Without continued investment, state advocacy groups are at risk of losing staff who have accumulated in-depth policy knowledge and built strong community and stakeholder relations.

As this paper has described, successful implementation of the ACA will require increased levels of support to address the broad range of issues covered by the law and the complexities of the political environments in which implementation will occur. Without continued investment, state advocacy groups are at risk of losing staff who have accumulated in-depth policy knowledge and built strong community and stakeholder relations.

One objective of this project was to calculate the resources state advocates require to effectively implement the ACA in the states. We estimate that supporting core advocacy capacity across all 50 states plus the District of Columbia would require an annual investment of approximately $17 million per year over the next several years. Supporting a truly robust system of advocacy, including enhanced capacity in areas such as consumer assistance and private insurance markets, would require additional resources.

The chart estimates the level of salary and general support required to maintain effective *core* advocacy functions in every state, sufficient to effectively engage in the work of implementation. It does not attempt to comprehensively address the funding needs for state health care advocacy organizations to the extent they are addressing additional issues or functions. *Nor does it attempt to assess resources that state organizations currently have in-hand to address ACA implementation.* This calculation is based on a model of advocacy that assumes that effective state advocacy organizations must have capacities in several key areas: policy and legal analysis, government affairs, communications, organizing and coalition coordination.

To prepare this estimate, states were categorized into four groups based on their population: small (population of less than 4 million); medium (4-9 million); large (10-20 million); and largest (over 20 million). Population figures are based on estimates by the U.S. Census Bureau, with a slight rounding-up (states with a population within 250,000 of the next level were placed in the next category).[26] An aggregate staffing level was developed for each group of states.[27] Salary estimates were based on the aggregate staffing level, an assumed skill mix for each group of states, and skill-specific local wages.[28]

This is not meant to recommend a funding level for a particular state or for a state in a particular population category. Individual states will have particular circumstances that need to be considered in determining the level of resources required in that state, so there could be wide variation in resource needs within categories. In addition, there is a continuum that may not be adequately recognized by broad groupings; some states may be on the cusp of moving into the next higher population grouping. The rounding-up only partially addresses this issue.

ACA Implementation in the States Core Resources Required for State Advocacy Organizations

State System of Advocacy Infrastructure	Level of Effort Based on Population			
	Small	Medium	Large	Largest
	< 4 M	4 - 10 M	10-20 M	>20M
	Number of FTEs			
Total FTEs required to implement core system of advocacy within states (Policy, Legal, Government Affairs, Communications, Organizing, Coalition Coordination)	2.5	4	6.5	9

Salary Estimates	Average Salary Per FTE based on Current Experience			
	Small	Medium	Large	Largest
	$47,600	$56,750	$66,000	$68,800
Subtotal	**$119,000**	**$227,000**	**$429,000**	**$619,200**

Benefits, Program and Overhead		Small	Medium	Large	Largest
Benefits	25%	$29,750	$56,750	$107,250	$154,800
Program, Travel etc.	15%	$17,850	$34,050	$64,350	$92,880
Overhead	10%	$11,900	$22,700	$42,900	$61,920
Subtotal		**$59,500**	**$113,500**	**$214,500**	**$309,600**
TOTAL PER STATE (plus DC)/YEAR		**$178,500**	**$340,500**	**$643,500**	**$928,800**

States in Each Category Listed Above	51	Small	Medium	Large	Largest
AR, AK, CT, DC, DE, HI, IA, ID, KS, ME, MS, MT, NE, NH, NM, ND, NV, OK, RI, SD, UT, VT, WV, WY	24	$4,284,000			
AL, AZ, CO, IN, KY, LA, MA, MD, MI, MN, MO, NJ, NC, OR, SC, TN, VA, WA, WI	18		$6,129,000		
FL, GA, IL, MI, OH, PA	6			$3,861,000	
CA, NY, TX	3				$2,786,400
AGGREGATE TOTAL FOR ALL STATES (plus DC)/YEAR				**$17,060,400**	

There should also be a Special Opportunity Fund to provide rapid support for addressing emerging issues.

The Role of Funders

The funding community includes many categories of funders, as well as funders with differing interests and missions. For example, funders may focus on helping seniors, children, immigrants or entire communities; on increasing social justice and reducing health inequities; or on strengthening prevention efforts, public health, or reproductive rights. Some funders may want to act in concert; others may prefer to act individually.

There are many ways in which funders can engage in and support the work of implementing the ACA. An August 2010 paper by Grantmakers in Health[29] identified many opportunities for funders to advance the goals of the law as well as the funder's individual goals. It draws on interviews with funders and advocates identifying six main categories of potential funder activity with regard to implementation of the ACA: public education, partnering with government, advocacy, policy research, convening, and program innovation and reform. It includes many examples and suggestions for programs and other initiatives, as well as potential collaboration and coordination activities.

This paper focuses on the important role and potential impact of state consumer advocates in implementing the law. In many cases, consumer advocates are ideally positioned to carry out the programs and activities of interest to funders and are uniquely able to access vulnerable populations and other key constituencies. Partnerships between funders and advocates that focus on key issues, activities and constituencies will be essential to move implementation forward.

A number of funding models could be used or adapted to fund implementation advocacy. The following major funding models are currently in use:

- Funding is provided directly to state and local groups. This model is very appropriate for local and state funders who are interested in supporting specific organizations and their programs. In addition, the close partnership that can develop between funders and grantees in this arrangement can be extremely productive in terms of identifying and meeting evolving state and local needs and new opportunities.
- Funding is provided directly to state groups with the advice and assistance of a national organization or network. In this model, the network does not directly allocate funds and may or may not provide fiscal and program oversight. In some cases, the role of the national network or organization is limited to providing technical assistance to the grantees. In others, the national network or organization is tasked with overall program management.
- Initial funding for a project is provided to a national organization or network, which then makes sub-grants to state and local groups to accomplish a portion of the project. This model may appropriate for those national foundations that wish to have a highly targeted funding strategy

Some funding models are more appropriate for certain funders than others, although whichever funding model is chosen should be supportive of state and local organizations. Coordination among funders greatly facilitates planning and implementation by the grantees.

An approach in which national organizations independently hire and place staff in a state has been tried and has failed. It is both inefficient and ineffective. It undercuts local efforts; often provides confusing, if not conflicting, messages; fragments grassroots efforts; and wastes resources. And when the resources are withdrawn, whatever had been accomplished is lost.

Conclusion

The ACA has the potential to make quality affordable health care available to millions of people who lack it today, but the road to successful implementation is rough and uncertain. Due to the critical role of state policy making in implementing the ACA, realizing the potential benefits of the law will require a substantial investment in ongoing advocacy at the state level.

State advocates need to be able to take on a wide range of advocacy tasks, including broad public education, policy and legal analysis, grassroots and netroots organizing, communications efforts encompassing traditional and alternative media, coalition-building, and administrative and legislative advocacy. These state-level activities need to be supported and complemented by federal policy advocacy and coordinated technical support. An optimum investment strategy will target states across diverse environments and engage new funders in actively supporting state-based health consumer advocacy.

The organizations contributing to this report share the belief that a coordinated national-state advocacy effort is essential to successful implementation of the ACA. They also agree that successful implementation of the ACA has the potential to have a positive impact on ongoing societal problems related to social justice, health equity, poverty, public health, and health care delivery. Local, state and national funders with an interest in these issues thus have a strong reason to contribute to effective advocacy efforts. This plan is designed to provide a roadmap to the scope and nature of the work that lies ahead.

Endnotes

[1] Atlantic Philanthropies; The California Endowment; The David and Lucile Packard Foundation; the Nathan Cummings Foundation; and The Robert Wood Johnson Foundation

[2] Center on Budget and Policy Priorities; Community Catalyst; Families USA; Georgetown University Center for Children and Families; Health Care for America Now; and Trust for America's Health

[3] These advocacy activities can be carried out by either 501(c)(3) or 501(c)(4) organizations. 501(c)(3) organizations that take the subsection (h) election are permitted to spend a significant, but not unlimited portion of their budget on legislative activities (15 to 20 percent, up to $1 million) while 501(c)(4) organizations may use unlimited resources on lobbying. 501(c)(3) organizations face other limitations on advocacy activities. While this plan references only activities that can be accomplished by 501(c)(3) organizations, engagement by 501(c)(4) organizations will be necessary to perform the continuum of activities necessary to support the ACA.

[4] Grassroots activism organized through blogs and other media, including wikis and other social network services

[5] David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler (2005). MarketWatch: Illness and Injury As Contributors to Bankruptcy. Health Affairs http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1

[6] The Institute of Medicine (2003). A Shared Destiny: Community Effects of Uninsurance. http://www.nap.edu/catalog.php?record_id=10602

[7] Wilkinson and Picket, The Spirit Level, Penguin 2009

[8] In the recent election six Senate seats and over 60 House seats changed from Democratic to Republican control (although in the House, not all shifts in party reflect a shift in position on the ACA). Also of significance for implementation, 11 governorships recently held by Democrats will switch to Republicans, many of whom featured their opposition to the ACA as part of their campaigns.

[9] http://www.kaisernetwork.org/health_cast/uploaded_files/Moffit_Report.pdf

[10]http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/1367_Gabel_does_CBO_underestimate_savings_from_reform_ib.pdf

[11] http://people-press.org/trust/

[12] http://www.cbpp.org/slideshows/?fa=stateFiscalCrisis

[13] For a more complete summary see http://www.kff.org/healthreform/upload/8061.pdf

[14] Congressional Budget Office (March 2010). Estimates for March 2010 Health Care Legislation http://www.cbo.gov/publications/collections/health.cfm

[15] Pregnant women and children are covered by Medicaid or CHIP at state option

[16] Includes low-income individuals who are uninsured (10.5 M), have non-group, other public and Medicare coverage (4.0 M), or have employer-sponsored insurance (4.1 M).

[17] Includes subsidy-eligible uninsured in families with large, mixed and small firm employment as well as subsidy-eligible uninsured in families with self-employment, part-time employment or not attached to the work force.

[18] The CBO estimated 32 million people would have coverage in 2019 under the ACA but would have been uninsured under prior law. The CBO expects millions of additional people to remain uninsured. The number who could actually obtain coverage is substantially higher if enrollment barriers are successfully eliminated.

[19] The Henry J. Kaiser Family Foundation (September 2010) Health Reform and Communities of Color: Implications for racial and ethnic health disparities http://www.kff.org/healthreform/upload/8016-02.pdf

[20] http://www.kff.org/pullingittogether/040610_altman.cfm

[21] www.cbpp.org/files/10-21-10health.pdf

[22] http://www.field.com/fieldpollonline/subscribers/Rls2336.pdf

[23] http://www.kff.org/kaiserpolls/posr042210nr.cfm

[24] John Holahan and Linda Blumberg (January 2010). How Would State Be Affected by Health Reform? http://www.urban.org/uploadedpdf/412015_affected_by_health_reform.pdf

[25] Robert Wood Johnson Foundation provided $10.1M to 18 states through Consumer Voices for Coverage; Public Welfare Foundation provided $7.5M to 11 states; the Packard Foundation provided $4.7 million to 14 states through the Insuring America's Children Initiative; and Community Catalyst's Hospital Accountability Project provided sub-grants totally $2.2 M to 13 states. Regional, state and local foundations provided additional funding in many states. In addition to these programs to strengthen core capacity, other funding has been available to support specific activities; for example, $17M of 501 (c)(4) funding was provided to HCAN to support organizing efforts in the field over the 18 months prior to passage of the law.

[26] U.S. Census Bureau, Population Division, Table 1: Annual Estimates of the Resident Population for the United States, Regions, States and Puerto Rico, Release Date: December 2009

[27] An estimated aggregate staffing level was established for each of the four groups of states based on the required capacities and the average population in each group. These are the core staffing levels that are required to do the basic work of implementation. However, this does not necessarily reflect the actual staffing needed in a given state. Each organization will need to find the specific staffing mix and level that best reflects local need.

[28] This figure represents an estimated average cost per FTE per state grouping. Relative salary levels are based on population groupings only. Totals also reflect the variation in the cost of staffing each capacity, weighted by an assumed staffing mix for each group of states.

	Small		Medium		Large		Largest	
	FTE	Salary	FTE	Salary	FTE	Salary	FTE	Salary
Policy/Legal/Government Affairs	1	52K	1.5	58K	1.5	65K	2	65K
Communications	.5	45K	1	55K	1	65K	1	65K
Organizing	.5	35K	1	45K	3	55K	4	55K
Coalition Building	.5	55K	.5	80K	1	102K	2	102K
Total/Average	**2.5**	**47.6K**	**4**	**56.7K**	**6.5**	**66.1K**	**9**	**68.8K**

[29] Implementing Health Care Reform: Funders and Advocates Respond to the Challenge," Grantmakers in Health, August 2010.

Appendix A: Critical Implementation Issues

Section IV of this report presented a brief overview of the provisions of the ACA and of implementation issues of particular importance to low- and moderate-income families, communities of color, people with chronic illnesses, and other at-risk populations. This appendix provides greater detail on these key issues.

State Administrative Capacity and Will

Unlike Medicare, which is administered wholly by the federal government, the ACA, like Medicaid, is administered jointly by the federal and state governments. Under the ACA, states play a major role in setting policy within a framework established by the federal government. In this model, the states will be asked to assume myriad responsibilities related to implementation, such as modifying their Medicaid programs, strengthening their regulation of insurance premiums, instituting numerous health insurance market reforms, and running health insurance Exchanges. However, one critical issue often overlooked is the variable and often weak administrative capacity of states. Historically state administrative activities have tended to be underfunded since there is less of a constituency for them than for direct services. This problem has been exacerbated by the severe fiscal constraints imposed on states by the economic downturn, which has resulted in layoffs of staff administering Medicaid, CHIP and other programs. Adding to the challenge is the fact that a number of governors and state legislatures are politically opposed to ACA and may be unwilling to invest the resources needed to make the law a success. Term limits, which tend to erode the institutional memory of state governments, can add yet another layer to the difficulties of state implementation.

Medicaid and CHIP

Under the ACA, enrollment in Medicaid and CHIP is expected to increase by 16 million; this is about half of the projected total increase in people with insurance coverage that is expected to result from implementation of the law. Although the CHIP reauthorization law established some financial incentives for states to enroll low-income children, and the federal government will pick up the vast bulk of the costs of the Medicaid expansion, some states may keep barriers to Medicaid enrollment that many eligible individuals and families currently face – or possibly erect new barriers – as a way to lower their costs. States retain significant discretion over their Medicaid programs. The choices they make will have major implications for the overall success of the law. States must:

- Modify their eligibility, outreach and enrollment practices to be consistent with the ACA, including changing what they count as income in Medicaid and CHIP and who is considered part of a coverage unit. This is necessary to align Medicaid and CHIP rules with federal income tax rules, which will be used to determine people's eligibility for premium subsidies.
- Create a system to coordinate Medicaid and CHIP eligibility with eligibility for subsidies within the Exchange, including finding a way to appropriately address changes in people's income and household composition during the year.

- Determine the benefit package that will be available to newly eligible enrollees, which may be – but does not have to be – the same as the benefits generally available in Medicaid. Medicaid benefits typically meet the needs of people with significant medical needs and chronic conditions; benefits for newly eligible enrollees could be less comprehensive.

As the federal government will pick up the vast majority of the costs imposed by the Medicaid expansion, the cost burden on states has been greatly overstated by some critics. However, states will incur some additional costs, although these costs will be modest. These new costs could be met by identifying new financing sources for Medicaid and CHIP, but some states may try to address the problem through additional changes in Medicaid policies. A key question for advocates is whether those changes will be positive or negative.

For example, since in most cases states will not be able to limit Medicaid eligibility, some states may consider "thinning the soup" by reducing the scope of their existing Medicaid benefits package. Another tactic states have historically used to limit costs is reducing provider reimbursement rates. In some states, this has resulted in reduced access to care, particularly access to certain kinds of specialty care. As an alternative, states could improve the value they get for their Medicaid dollars by changing the way they deliver and pay for health services, for example by implementing measures designed to reduce preventable hospitalizations and institutionalizations. States can also work to align incentives for better value. The ACA creates new opportunities for states to achieve these types of system savings. States are already seeking to enroll populations previously exempted from managed care requirements into capitated arrangements. Advocacy will be needed to ensure these health plans meet the needs of the generally sicker and higher-cost populations subject to these new arrangements.

States will face other issues in addition to the ones described above. For example, they will need to distinguish between beneficiaries who qualify for enhanced federal matching rates and those who were already eligible, without having to apply two different sets of eligibility rules. They will need to meet the requirement to provide benchmark benefits to newly eligible adults. They also will need to establish rules to coordinate Medicaid and CHIP eligibility with subsidies in the Exchange, as well as ways to make it easy for people to move among coverage options when they cease being eligible for one program and become eligible for another. To facilitate enrollment, they may be able to use eligibility determinations made for other public safety-net programs to establish Medicaid and CHIP eligibility, which would simplify enrollment and lower states' administrative costs. Getting the rules right both at the federal and state level will affect how easily states can implement the expansion and how well the new coverage meets the needs of low-income beneficiaries.

Even prior to the implementation of the new law, Medicaid and CHIP funding may be threatened as states look for ways to cope with their budget problems. One particular concern is that some states could try to scale back efforts to enroll more eligible uninsured children in Medicaid and CHIP, undercutting the striking progress that has been made in recent years. This would leave more children without coverage until 2014.

Insurance Exchanges and Market Reforms

Within a framework established by the federal government, states will have broad discretion over the creation and operation of insurance Exchanges. States must decide:

- whether they will operate an Exchange or let the federal government do so
- whether to have one or multiple Exchanges or collaborate with other states to run a multi-state Exchange
- how to set up the Exchange's operating structure, such as within a state agency or quasi-public entity, or through an outside entity with which the state contracts
- how to adequately finance the Exchange once federal start-up funds expire
- whether to have a single state agency process eligibility determinations and renewals for Medicaid, CHIP and Exchange subsidies using a joint application or to distribute these functions among agencies
- how the Exchange will be governed including how various stakeholders can participate in key decisions that will set the policies under which the Exchanges operate and monitor their ongoing operations
- how much authority to give the Exchanges to structure the insurance market and negotiate with health plans. For example, Exchanges could limit the variability in benefit design beyond what the federal law requires to limit adverse selection and, if authorized, negotiate aggressively with health plans on price

With respect to the private insurance market, the ACA mandates important changes such as eliminating pre-existing condition exclusions; prohibiting experience and gender rating; and setting minimum standards for plans' actuarial values and covered benefits. However, it also allows certain practices that could undermine Exchanges unless states are proactive. For example, the ACA does not require states to apply the same rules to insurers selling products within the Exchanges and those operating in the individual and small group markets outside the Exchanges. These include rules related to the marketing of plans, their benefit design, quality assurance, and plan offerings. Such an unlevel playing field could make it easier for insurers outside the Exchanges to "cherry pick" healthy enrollees, leaving the Exchanges to cover populations that are sicker than average. This would drive up premiums and could threaten the long-term viability of the Exchanges.

Furthermore, the market reforms described above, as well as requirements that insurance regulators review unreasonable insurance premium increases, depend primarily on states for their success. States must be willing and able to effectively enforce these provisions, including providing the necessary resources for effective monitoring and enforcement. States that currently have weak regulatory structures and oversight capacity are typically states where insurers hold the most sway; they will also be the ones that will need to make the greatest strides in overseeing insurer behavior. In addition, the contentious debate over abortion coverage that occurred at the federal level is likely to replicate itself in the states as they make decisions about coverage and benefits.

Federal regulators will also have to make important decisions regarding the Exchanges and insurance market reforms. These include:

- defining the essential benefit package, how the actuarial value of plans is calculated, and what is permitted with respect to "value-based" benefit design
- defining the parameters for state flexibility with respect to setting up their Exchanges
- setting criteria used to determine whether the federal government needs to step in and establish an Exchange and creating "fallback" Exchanges for states that are unable or unwilling to set up their own
- providing planning grants to help states establish Exchanges and determining what the grants can be used for
- outlining options for states in structuring their Exchanges and mitigating the risk of adverse selection in the Exchanges
- providing states with additional guidance on determining how risk adjustment and pooling will be implemented by the states
- structuring incentives to support stronger state oversight of insurance premium increases
- specifying how states must institute the major insurance market reforms, such as requiring adjusted community rating

Slowing the Rate of Growth in Health Care Costs

While the success of the ACA will rise or fall with actions across the states, the parameters for state action will be set by federal rulemaking. Moreover, key federal decisions that lie entirely outside the purview of the states will have a major impact on the substantive and political success of the law. Perhaps no constellation of decisions is more critical to the ultimate fate of the ACA, not to mention the long term fiscal health of the U.S. government, than those that aim at moderating the growth in health care spending while improving quality. A recent international comparison has shown yet again that the U.S. spends amounts far in excess of other countries on health care while still performing poorly on measures of quality.[1] Because health care spending is highly concentrated among the elderly, and particularly among low-income seniors dually eligible for Medicare and Medicaid (who account for nearly half of all Medicaid spending), several new federal bodies — the Center for Medicare and Medicaid Innovation, the Federal Coordinated Health Care Office, and the new Medicare commission (IPAB) — will be the focal point of federal, and to some extent state, cost-containment efforts. These efforts present two risks — that they will not be sufficiently aggressive to actually contain costs and that they will reduce costs at the expense of the quality of care for vulnerable beneficiaries, such as the dual eligibles. This makes it essential for consumer-oriented groups to create and sustain an organized and active consumer voice in decisions related to Medicare and Medicaid payment and delivery system reform.

The ACA also requires the federal government to experiment with a number of new health care delivery system models within the Medicare program, such as the creation of medical homes, establishment of accountable care organizations, and bundling of payments to groups of providers rather than paying individual doctors according to the number of procedures they perform. Some of these models will also be tested within Medicaid, thus involving partnerships with the states. These models' success in lowering costs will be important to efforts to slow cost growth, which could ease pressures on state budgets over time. It will be important to ensure that such models are patient-centered and do not lower costs at the expense of access to effective care.

Heath Care Workforce

An issue that affects ACA reforms to both public programs and the private insurance market is the availability of an adequate health care workforce. Typically the uninsured do not have the same access to ambulatory care as the insured population. With an influx of more than 30 million newly covered people into the health care system, demands on an already stretched primary care workforce will increase. Addressing this issue is important to help realize benefits of the ACA. Moreover, the potential shortage of primary care providers is not only an important substantive issue; if a significant number of newly insured people cannot access primary care, that could weaken political support for the new law.

The ACA begins to address this issue through a significant expansion of funding for Community Health Centers and the National Health Service Corps, training and loan-forgiveness programs for primary care physicians, changes to how Medicare reimburses for primary care, and a temporary two-year increase in Medicaid primary care physician rates, which will be fully funded by the federal government. But it takes time to bring new clinicians on line and, given the increase in demand, these measures will probably not be sufficient.

States and advocates committed to successful implementation of the ACA will need to support additional initiatives to more quickly increase the supply of primary care providers. One approach would be to expand the roles and number of other types of health care practitioners, such as advanced practice nurses and physician assistants. In addition, a cost containment strategy that relies on reducing preventable institutional admissions requires a robust community care delivery system that includes not only clinicians but personal care and home health workers, community health workers and promatoras.

Consumer Assistance

The creation of a consumer assistance infrastructure to help people navigate the reformed health care system is an essential component of implementation. Experience with the introduction of previous state and federal reforms, such as Medicare Part D drug coverage and major changes to Florida's Medicaid program, demonstrates that failure to invest adequately in this function can create major confusion for consumers. In Massachusetts, Health Care For All's consumer assistance line experienced a four-fold increase in the volume of calls following passage of the state's reform law; four years

later, the volume of calls is still more than three times greater than it was prior to the state's reform.

Even prior to implementation of the ACA, consumer assistance programs provide material support to consumers on a range of issues, such as eligibility for public and private insurance programs, the availability of hospital financial assistance programs for patients with unaffordable hospital bills, and procedures for filing grievances and appeals with private insurers.

Resources will be needed to create new consumer assistance programs and to train people currently engaged in health and low-income outreach programs in the new rules and procedures related to Medicaid eligibility and receipt of subsidies in the Exchanges. The ACA provides a small amount of initial funding to support state consumer assistance programs. It also requires states to fund consumer assistance programs to help consumers purchase insurance and resolve problems in the Exchanges. Without advocacy, however, these programs are unlikely to provide the level of support consumers will need. If well-designed and adequately financed, consumer assistance initiatives can also identify operational problems in coverage programs and provide important feedback to government officials on how the ACA is working "on the ground" for individuals and families.

Another area of needed consumer support is taxpayer assistance and counseling programs for low-income people. Counseling services are needed because people's eligibility for insurance premium subsidies will be affected by the information in their tax returns. The ACA does not provide resources to support this type of assistance.

Failure to adequately support consumers in the reformed health care system could cause hardship to individuals.

Community Transformation Grants

The ACA provides grants to state and local governmental agencies and community-based organizations to support community disease prevention activities designed to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop stronger evidence for effective prevention programs. As a result, they can help pave the way for some measures to slow the growth of health care costs. The Community Transformation Grants also offer state-wide consumer health advocacy organizations an opportunity to further strengthen their ties to the community, particularly among low-income people and people of color. They also have the potential to provide tangible benefits to underserved communities immediately.

These grants could provide the resources to launch an entirely new approach to state and local prevention and public health efforts. By focusing on interventions at the structural and policy levels that cut across disease "stovepipes," it could shift focus to some of the social and structural determinants of health to ensure healthier communities. Done right, it could also engage a broader cross section of players, such as business people, consumers, and community-based organizations, in the work of public health. The key short-term challenge will be articulating an effective vision for this program and developing a consensus among key players. The long-term challenge will be the allocation of sufficient funding and motivation as well as capacity at the state and local levels.

Public Health Infrastructure

The ACA establishes a Prevention and Public Health Fund. It provides up to $2 billion per year to support expanded and sustained national investment in disease prevention and public health programs designed to improve health and help restrain the rate of growth in private and public sector health care costs. It provides funding to state and local health departments, with a particular focus on making health departments more effective in areas related to health care system reform. However, to make progress, states will need to compete for funds and use the new revenues for new programs, rather than to supplant existing funding.

Key federal policy challenges include building consensus at the national level about what constitutes appropriate expectations for the grants and then assuring that states and localities are held accountable for the use of the funding. Given the difficulty in obtaining funds for ACA implementation from a more conservative and deficit-conscious Congress, preserving these funds for their intended purpose will also constitute a significant challenge.

Health Equity

The ACA includes provisions that, if implemented effectively, would reduce racial and ethnic health disparities and promote health equity. Provisions that offer the greatest opportunities for consumer advocates include those that:

- help expand and diversify the health care workforce
- establish a national quality strategy to improve delivery of care, patient outcomes and population health, including a reduction of health disparities
- develop a national prevention strategy and grants for community health programs and community health workers to promote wellness and address disparities
- support the inclusion of programs and payment incentives in health plans sold through the Exchanges that are designed to reduce disparities
- support programs that develop cultural competency and health disparities curricula for use in health profession schools and continuing education programs

Unfortunately, certain provisions of the ACA that relate to immigrants could increase rather than reduce disparities. The law continues the current policy of excluding legal immigrants other than children and pregnant women from Medicaid during their first five years in the country. It prohibits undocumented immigrants from accessing new insurance subsidies and from buying insurance coverage through the Exchanges, even if they use their own funds, although legal immigrants are eligible for premium credits for coverage purchased through the Exchange.

Due to the expectation that the new law will result in a substantial drop in the number of uninsured, the ACA cuts Disproportionate Share Hospital (DSH) payments to hospitals that now treat large numbers of uninsured.[2] However, hospitals in states with large immigrant populations (and states that leave many individuals who are eligible for Medicaid, CHIP and premium credits unenrolled) may still require considerable funding for providing uncompensated care, and there is a danger that funding might not be adequate after full implementation of the law.

Safety Net, Charity Care and Community Benefits

The ACA includes provisions that will have an impact on public and private safety-net programs. Some provisions clarify non-profit hospitals' obligations to provide charity care to needy patients and benefits to their communities. They establish requirements for how hospitals notify patients about the availability of financial assistance; charge and take collection actions against uninsured and underinsured patients; and establish a public process to develop community benefit plans. In addition, as mentioned above, states will lose federal Medicaid DSH funds as the number of uninsured people declines. In the face of this funding reduction, states will have incentives to better target their DSH dollars to those hospitals serving the greatest proportion of low-income people. These requirements are among a small number of ACA provisions that benefit low-income people in the short run (prior to 2014).

If implemented effectively, these provisions can promote better access to hospital and specialty care and over time, in conjunction with Community Transformation Grants and other public health provisions, begin to address more environmental and population-based health issues. Furthermore, many low-income people will remain uninsured even after 2014; these safety-net provisions will be particularly important for those who still find insurance premiums unaffordable and for undocumented immigrants who are ineligible to receive premium subsidies. In addition, experience in Massachusetts and other states demonstrates that increased accountability and transparency in safety-net programs also increases the likelihood that advocates will be able to develop alliances with providers, insurers and employers on coverage issues. However, without state enforcement and active community engagement, these important provisions are at risk of being overlooked and their potential unrealized.

The ACA also creates a $10 billion mandatory appropriation to support a major expansion of the Community Health Centers (CHC) program and the National Health Service Corps over the next five years. These programs are run by the Health Resources and Services Administration (HRSA). These funds are intended, in part, to build capacity to meet the increased demand that may result from the growth in the number of people who have insurance coverage. It is not yet known how HRSA will make decisions regarding the locations of the new health centers, but states will want to maximize their ability to take advantage of this vehicle for expanding access. In addition, HRSA has indicated particular interest in working with state and local health departments that run primary care clinics, to assist them in converting these clinics to CHC status. This could be a critical source of new revenue.

Premium Credits and Reductions in Cost-Sharing Charges

Under the ACA, people will obtain insurance premium subsidies through the Exchange. The subsidies will be provided through a system of premium credits based on income eligibility. People's eligibility will be based on their prior year's tax returns, and the federal government will have to determine what happens when people's income or family circumstances change after they file their return. The federal government will also have to design an effective process for ensuring that people with incomes below 250 percent FPL can enroll in plans with higher actuarial values and lower cost-sharing, as allowed in the law.

Employer and Individual Responsibility

The ACA does not address some important questions related to the employer and individual responsibility components of the law — that is, the provisions that require most employers to offer insurance coverage and most individuals to have coverage. For example, the law does not fully articulate the circumstances under which an employee or their family members may access Exchange subsidies when employer-sponsored insurance (ESI) is available or what constitutes a hardship for the purposes of exemption from the individual responsibility requirements.

A threat to the success of the ACA is that some employers may seek ways to shift their employees from ESI coverage to the subsidized Exchange, for example reclassifying workers as independent contractors. In this regard, the experience in Massachusetts is encouraging; the state's reform appears to have actually strengthened employer incentives to provide insurance. Nonetheless, given that the individual and employer requirements in the ACA are structured somewhat differently from those in Massachusetts, careful monitoring of any employer efforts to shift coverage of their workers to the Exchange and bypass the employer responsibility requirement will be necessary.

Basic Health Plan (BHP)

Under the ACA, states have an option to create a Basic Health Plan (BHP) for people with incomes below 200 percent FPL. Rather than receiving federal subsidies to purchase insurance through the Exchanges, these individuals would be enrolled into the alternative state-designed managed care plan, which could build on existing state Medicaid or CHIP managed care arrangements.

The federal government will set key rules for BHPs. These include determining the level of benefits they provide, their cost-sharing and consumer protection requirements, and how savings states may reap by implementing the plans can be used. A well-structured BHP could give low-income beneficiaries better coverage than they might otherwise obtain in the Exchanges. It could also enable parents and children to be covered by the same health plans and use the same providers even though they are enrolled in different programs (Medicaid, CHIP or BHP). This could increase participation among eligible families and improve access to care. On the other hand, a poorly designed BHP could create problems if it led to inadequate coordination of coverage under the BHP, Medicaid and the Exchange. In addition, depending on how a state structures its Exchange, a BHP could leave the Exchange without a sufficient pool of enrollees and make it less viable.

The federal government must also set rules related to a provision in the ACA that allows states to seek waivers enabling them to opt out of many measures in the law. For example, states could seek waivers that would allow them to bypass or modify the individual and employer responsibility requirements of the law, the essential benefits package requirements, the rules governing the Exchanges and other market reforms. States cannot seek these global waivers until 2017.

Legislative Improvements to ACA

In the current political environment, making technical corrections to or amending the ACA is not feasible. Nonetheless, several aspects of the law would benefit from amendment and the groundwork should be laid now to take advantage of opportunities to improve the law in later years. Foremost is the need to improve the law's affordability provisions for low- and moderate-income families.

Another possible set of issues relates to how household composition is defined when determining eligibility for both Medicaid and premium subsidies in the Exchange. This is especially true for children whose non-custodial parents claim them as tax dependents.

The ACA also continues to exclude legal immigrants (except children and pregnant women) from Medicaid coverage during their first five years in the country. As well as being inequitable, this will likely increase the number of people who remain uninsured after implementation of the ACA.

In addition, most members of the advocacy community promoting reproductive health see the ACA as a mixed bag at best, given its restrictions on abortion coverage, and a longer-term strategy will be needed to address the problems in this area. (Note: this section is intended to be an illustrative list of some of the potential future legislative improvements.)

[1] *http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf*

[2] *Disproportionate Share Hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. Medicaid DSH payments are the largest source of federal funding for uncompensated hospital care*

Appendix B: Existing Coordination Initiatives by National Organizations Related to Federal and State Implementation of the ACA

Federal Implementation Work

Coordination on overarching strategy. Under the auspices of the Health Information Center, a new non-profit that grew out of the health care working group of the Common Purpose Project, a number of national organizations meet regularly to coordinate public education activities and responses to misinformation and misperceptions about the law.

Guide to Acronyms

ACA	Affordable Care Act
AFL-CIO	American Federation of Labor and Congress of Industrial Organizations
AFSCME	American Federation of State County and Municipal Employees
CBPP	Center on Budget and Policy Priorities
CC	Community Catalyst
CCF	Center for Children and Families
CMI	Center for Medicare and Medicaid Innovation
DOL	Department of Labor
FUSA	Families USA
F-SIP	Federal-State Implementation Project
HCAN	Health Care for America Now!
HHS	Department of Health and Human Services
KCMU	Kaiser Commission on Medicaid and the Uninsured
NAIC	National Association of Insurance Commissioners
NHeLP	National Health Law Program
NPWF	National Partnership for Women and Families
NWLC	National Women's Law Center
OCIIO	Office of Consumer Information and Insurance Oversight
SEIU	Service Employees International Union

Policy work groups on key implementation issues. Given the extensive federal policymaking required to implement the ACA, we have established a number of policy workgroups — many of which include state advocates — to address key federal implementation issues, including:

- **Private Insurance Reform work group.** NPWF organizes a network of national organizations with expertise on private insurance reform and insurance exchanges to gather comments on regulations, make joint recommendations to the administration, and provide policy support for consumer advisors to the NAIC. Several subgroups, chaired by various organizations with particular expertise in relevant areas, have formed to review particular regulations and issues in greater depth.
- **Medicaid and CHIP policy work group.** FUSA, CCF and CBPP, building on a network of policy experts who focus on low-income populations that was established during the legislative debate on the ACA, participate with other national policy organizations (NHeLP, KCMU, CC and others) and state advocates in reviewing the language of the ACA, identifying key regulatory issues, and providing comments to HHS. When needed, the work group taps into the broader network of groups in FUSA's long-standing Medicaid Coalition.
- **Children's health network.** CCF, along with FUSA and CBPP, help to convene a network of provider and child health advocacy organizations that meets weekly to review regulatory issues that have a particular impact on children and to devise and implement strategies for working with HHS officials to secure the best possible regulatory decisions.

- **Campaign for Better Care.** NPWF, along with NHeLP and CC, lead efforts to coordinate federal and state advocacy activity to promote better care, especially for Medicare recipients and those dually eligible for Medicare and Medicaid, and to monitor ACA provisions related to the CMI and other payment and delivery system reforms.
- **Consumer Assistance work group.** CC, along with the Community Service Society of New York and Health Care For All in Massachusetts, is co-leading a work group aimed at promoting the development of robust consumer assistance programs.
- Other policy and advocacy networks. One or more organizations also participate in – or work closely with – important networks involved in federal implementation of health reform, including:
  - Consortium for Citizens with Disabilities health task force
  - CCF/CBPP-led waiver task force, which has already provided comments to HHS on waiver provisions of the ACA
  - National Immigration Law Center's coalition of organizations considering the impact of health reform on immigrants
  - HCAN's Legislative and Policy Committee and Steering Committee, which bring together labor and progressive partners focusing on insurance industry accountability and other elements of implementation

Identifying policy gaps. F-SIP links policy researchers, state and national advocacy organizations, foundations and federal and state implementers to identify areas where new or additional substantive work is needed to help guide implementation and facilitate connections when necessary.

Message development through the Herndon Alliance. HCAN and other groups have worked closely with the Herndon Alliance to conduct polls and focus groups that inform the development of messaging designed to create public support for the ACA.

Meetings with Congressional staff. Various groups have met with Congressional staff, including committee staff overseeing implementation in key areas.

State Implementation Work

Coordination among national organizations to gather input from and provide technical assistance to state groups. CC, FUSA, CCF, and CBPP have made a major commitment to coordinating their work with state organizations. At meetings originally convened by CC, CBPP and CCF in April, and now also attended by FUSA, the four organizations develop coordinated strategies for gathering information on implementation issues arising in the states; foster cross-state information sharing; and support state groups in capacity building, strategic communications, and policy analysis. The organizations also communicate biweekly to plan regular conference calls they conduct jointly with state advocacy groups to review issues emerging in the states, announce upcoming policy papers, and share information about work with or travel to a particular state. (See the next item.)

Regular conference calls with state groups on policy and strategic issues. Building on a series of calls initiated during the legislative debate over the ACA, CCF, CC, CBPP, and FUSA jointly sponsor biweekly calls with key state advocates to discuss policy,

communications and strategic issues related to health reform implementation. The calls allow for an exchange of information between national and state advocates and among state advocates. In addition, HCAN convenes a weekly conference call of its network of partners in approximately 35 states to discuss implementation.

Coordination of enrollment efforts. A new organization, Enroll America, is coordinating a broad and diverse initiative to secure optimal enrollment of people eligible for Medicaid and CHIP as well as for subsidies to afford private plan premiums. In addition to the participation of national and state-based consumer organizations (especially representing low-income families, communities of color, and people with disabilities or other health problems), Enroll America is a cooperative effort that involves the major companies and associations representing the insurance, pharmaceutical, hospital, physician, nursing and medical device sectors. It will promote optimal enrollment systems in states around the country through two specific efforts. First, it will create and support state-based "enrollment collaboratives" in all 50 states composed of diverse consumer and health industry groups that will work with state governments to secure enrollment-friendly systems and procedures. Second, through its Best Enrollment Practices Institute, Enroll America will reach out to diverse health stakeholder organizations and leaders in the 50 state collaboratives so they understand what works and doesn't work in promoting optimal enrollment.

Participation of state groups in work groups on federal regulatory issues. Many experienced state advocates participate in the policy work groups on federal implementation issues that were described previously. For example:

- a number of state-based advocates who are NAIC consumer representatives work with the Private Insurance Reform work group
- state advocates participate in a monthly call with the Medicaid policy work group to help shape its work; for example, CBPP led a call with state advocates to discuss the benefit packages that can be provided to newly eligible Medicaid beneficiaries
- FUSA has set up an email network with state-based advocates to inform them about Exchange and private insurance work
- CCF participates weekly in a Voices for America's Children call with leading state child health advocates to foster a health reform "feedback loop"

Combating state nullification efforts. HCAN, CBPP and the Ballot Initiative Strategy Center coordinate on issues related to state ballot initiatives opposing or threatening to undermine reform.

In-person meetings of state advocates. Since January, FUSA, CCF, CC and CBPP have been sponsoring national, regional, and state-specific meetings with hundreds of advocates to exchange information and ideas on advocacy strategies and policy issues related to the ACA. The national organizations have worked together to plan these meetings and have made presentations at each other's meetings.

"As-needed" calls and communication. In addition to the regular calls and meetings described above, CC, CCF, FUSA, and CBPP work with state groups on an as-needed and often emergency basis to foster the exchange of ideas and information. For example, our organizations worked with Arizona advocates to respond to inaccurate charges that the health reform law caused insurance premiums for state employees to skyrocket.

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Where the Rubber Meets the Road:

Strategies for Successful State Implementation of the Affordable Care Act

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