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Barber Shops, Salons, and Spas: The Complexity – and Simplicity – Of Implementing Outreach and Enrollment Contracts Under The Affordable Care Act

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Its primary goal was to extend affordable, comprehensive, and quality public and private health insurance coverage as widely as possible and to contain growth in health care spending through new regulations on consumer protections, creation of insurance marketplaces, individual mandates for purchasing health care, Medicaid expansion, and other reforms. The ACA was implemented through a complex system of formal and informal arrangements among federal, state, nonprofit, nongovernmental, and private institutions. This study analyzes the implementation of a central element of the law in six states, drawing on data we collected in 2015 and 2016 through semi-structured interviews with forty key program stakeholders. The objective of our inquiry is to identify factors that facilitated and inhibited implementation, and their influence on achieving the law's objectives.

The ACA is unique in terms of its scope, political controversy, and perhaps most importantly, its impact on uninsured individuals and the American social safety net (Nathan, 2016). The law offers an opportunity to examine a variety of key governance issues including its reliance on inter-organizational collaboration, and on "market" strategies such as private insurance markets and government contracting. Like many public programs, the ACA relies on outsourcing as an important option for not only service delivery, but also for service support such as outreach, eligibility determination, and enrollment.

One of the prominent requirements of the law was the establishment of healthcare exchanges (or, marketplaces) through which individuals could review and purchase health care coverage (Sebelius Testimony, October 30, 2013.) To enroll qualified people, states were given the option to create their own exchanges or use the federal exchange – Healthcare.gov. Thirteen states opted for their own marketplaces, while the rest relied on the federal exchange and its web portals for state-specific plans and premiums (Kaiser Family Foundation, n.d., State Health Facts). Successes and failures of the information technology contracts awarded by state and federal agencies to implement health exchange web sites were widely publicized in the media and investigated (GAO, 2014).

However, less is known about another key aspect of the ACA implementation that involved significant contracting activity: outreach and enrollment services designed to "take-up" eligible uninsured individuals. Regardless of states' decisions on the type of marketplace exchange, the law

required all states to establish *navigator* programs for outreach and education, and gave the option to establish separate IPA (in-person assistance) programs with "*assisters*" to help individuals with applications and enrollment (Kaiser Family Foundation, 2013).[1] All states received substantial federal funding to support their outreach and enrollment programs, and most states contracted these functions to nongovernmental organizations. Many of them, in turn, subcontracted with other entities.

State outreach and enrollment programs were clearly perceived by policymakers as critical to outreach and enrollment support, meeting program goals, and enhancing outcomes (Sebelius, 2013). We draw on implementation and contracting theories to assess states' contracted outreach and enrollment services, but we focus primarily on the elements of collaboration and network theories, and whether and how they emerge in the design and impacts of state strategies. Our inquiry therefore treats ACA implementation as a case through which we can examine these theories in the context of a contemporary social welfare innovation of substantial scope.

We examined ACA outreach and enrollment dynamics in six states. [2] Each of the states created its own ACA marketplace exchange (as opposed to relying on the federal exchange). Each also expanded Medicaid to "capture" individuals with incomes above the previous Medicaid eligibility levels, but below the ACA premium subsidy thresholds. Although the law's original requirement for Medicaid expansion was eliminated due to the Supreme Court's 2012 *National Federation of Independent Business v. Sebelius* decision, each of our sample states retained Medicaid expansion voluntarily, as an essential element of its insurance expansion strategy, and contracted with nongovernmental organizations for navigation and enrollment services.

We observe variation in a set of states that did not differ substantially on the dimension of support for the ACA. We note that none of these states adopted anti-ACA stances such as those identified by Rigby (2012); unlike the 32 "resister" states she identified, none of these states filed lawsuits challenging the law, passed

[1] In some states, navigators provide both education/outreach and assistance with applications and enrollment; in others, states contract with navigators for outreach and education, but contract separately with assisters for enrollment, and in some states, both types of programs cover all elements of outreach, education, and enrollment (Kaiser Family Foundation, 2013). Private insurance brokers also served as assisters through marketplace exchange contracts (Corlette, Blumberg, & Wengle, 2014). Our analysis did not distinguish among the formal types of outreach/educators/assisters, but instead focused on each state's overall system for reaching, educating, and enrolling eligible individuals.

[2] The six states are Colorado, Connecticut, Kentucky, Maryland, Minnesota, and New York. We chose these states based on their shared approach to several key aspects of policy implementation, as well as their variation on several important dimensions that are equally germane to the goal of the study. We explain our state selection strategy in the Methods section.

legislation opposing any or all of its elements, or passed up federal implementation grants. Instead, our sample of states is comparable on the dimension of a willingness to expand Medicaid and aggressively pursue the ACA's provisions. Thus, our focus on this set of states limits the generalizability of the findings, but benefits from a reasonable level of policy comparability across cases. The latter is conducive to case study analysis and development of theoretical propositions. We look for patterns of variation or similarity within a subset of such states to shed light on how individually tailored state strategies supported the law's implementation. In examining the interview data, supplemented with administrative data and reports, patterns inductively emerged which indicated that the unique features of the ACA contracts in these states, combined with several other policy-related or environmental factors, fostered a richly collaborative, less formalized, explicitly networked approach to reaching eligible individuals than we might observe in typical contracts. The role and the characteristics of contracting that might have complicated implementation were, in effect, "drowned out" by clear patterns of highly collaborative arrangements that involved extensive chains of diverse outreach/enrollment actors. These actors ranged from experienced health advocacy professionals to community members recruited to find enrollees in places where they were likely to congregate such as barbershops, salons, and spas, as well as churches, schools, and hospitals. In short, the traditional model used in most social welfare programs – "intake" offices that process applications and determine eligibility – was replaced with a highly decentralized, outward-focused, community-based strategy designed to minimize barriers to enrollment.

Our data help explain how the sampled states' strategies created and supported collaboration, and how these strategies relate to the observed differences in the quality of collaboration and, ultimately, the ACA implementation. Our analysis focuses on questions we posed in the context of state enrollment success three years into ACA implementation: What were the dominant features of states' implementation tactics? How did they perform in terms of their sustainability and the program's goals? How did states address the challenges related to the involvement of multiple organizations, sectors, and levels of government, in their strategies?

In the next section, we provide the context for our research by briefly reviewing the law, as well as the scholarship on implementation, government contracting, and collaborative service delivery, all against the intergovernmental backdrop of the ACA. These themes, as derived from our review, frame our research questions and inquiry. We then follow with brief introductory summaries of the marketplaces for each state in our sample. Next, we describe our research strategy and present the results of our analysis. Finally, we conclude with implications for the observations that we derive from the patterns identified in the data.

THE BACKGROUND OF ACA IMPLEMENTATION

The Affordable Care Act (ACA) includes ten statutory titles and a wide range of reform elements, all delineated in a highly complex statute that exceeds 1,000 pages (Thompson, 2013). Peter May (2015) cites "the enormous complexity of the [law] marked by numerous provisions stitched together in search of a politically viable policy reform" (p. 277). The law's complexity, combined with its federal structure and highly contested politics, suggests that implementation would be fraught with familiar impediments: goal conflict and related agency problems inherent in a federal system; buy-in and action required from multiple organizations and actors (across sectors as well as federal levels); extensive accountability chains; institutional capacity deficits; and redistributive design, among others (Derthick, 1972; Matland 1995; Sabatier and Mazmanian, 1983; O'Toole, 1988; Peterson, Rabe, and Wong, 1986; Pressman, Wildavsky, 1973; Stoker, 1991; Van Meter and Van Horn, 1975). Indeed, the granting of implementation authority to states, reliance on private insurance markets as a foundation, and the inevitable role of contracting, are all essential components of the policy that had the potential to take the law through months, if not years, of implementation drag. States' extensive stakeholder engagement, combined with agreement among many stakeholders on the fundamental goal of the law – to increase insurance coverage – may have helped to reduce friction across organizations, governments, and sectors and result in improved individual experiences.

Despite attempts by President Trump and Congress since the 2016 election to "repeal and replace" Obamacare, the ACA had succeeded in extending insurance to some 20 million previously uninsured individuals by mid-2018 (Sullivan, 2017; Centers for Disease Control and Prevention, 2018). It has also garnered increased levels of political support. State outreach and enrollment systems have been successful in reaching sizeable numbers of eligible individuals.[3] As described below, in our six-state sample, there is evidence that many of the typical and uniquely ACA-related barriers to implementation were overcome through the design and establishment of effective outreach and enrollment strategies that relied on collaborative networks of community actors. These networks were able to craft comparatively simple systems that broke through the implementation complexity inherent in the law, thereby creating new capacity and achieving significant enrollment gains.

ACA Implementation and Contracting

[3] Whether or not agencies are "unable" to create a good or service, agencies may be constrained in terms of staffing resources and flexibility and may face political imperatives to outsource regardless of capacity.

The United States has a long tradition of reliance on the private sector for the delivery of public services (Savas, 2000). Contracts for case management for welfare to work programs, child welfare, Medicaid and other health and human services delivered through intergovernmental programs, administered jointly by the federal and state governments, have become common. The ACA – the largest social welfare and health policy initiative in decades – also relies heavily on intergovernmental systems. Responsibility for key aspects of the law's implementation was delegated to states, which in turn contracted with a variety of public and private actors to implement these functions. Many of these actors then entered into subcontracts, a phenomenon that is sometimes referred to as "contractual devolution" (Nathan & Gais, 1998).

While one ostensibly positive feature of contracting is a higher degree of flexibility and, in some cases, cost savings, contract performance can be complicated by informational asymmetries, low outcome measurability, high-cost management and oversight systems, or worse, by inadequately funded monitoring (Anna Amirkhanyan, Meier, & O'Toole, 2017; Johnston & Girth, 2012; Johnston & Romzek, 2010; Kelman, 2002; Milward & Provan, 2000). For services such as nursing homes (Amirkhanyan, 2008; Amirkhanyan, 2009; Anna Amirkhanyan, Kim, & Lambright, 2008), child welfare and other social welfare systems (Johnston & Romzek, 2008; Romzek & Johnston, 2005), municipal services (Brown & Potoski, 2003; Girth, Hefetz, Johnston, & Warner, 2012; Hefetz & Warner, 2004; Johnston & Girth, 2012) and mental health systems (Milward, Provan, Fish, Isett, & Huang, 2010), aligning the incentives of the contracted agency with governmental objectives has proven to be demanding in that it amplifies the implementation management barriers cited in scholarship on street-level bureaucracy and bureaucratic discretion (Lipsky, 1980).

For contracts involving intergovernmental programs, complexity is an inevitable consequence of grafting new regulatory and administrative infrastructure onto already complex service-delivery, advocacy, and other types of institutions that encompass multiple organizations, programs, and actors spanning sectors and governments. In the context of the ACA, these include institutions related to the Medicaid program, various public health programs, and state-regulated private health insurance industries, among others. Another salient feature of the ACA's implementation environment common to intergovernmental programs is the level of uncertainty surrounding the future political and financial direction of the entire program and its various components. As the initial federal grants for navigation and outreach expired, states with market exchanges grappled with both the mechanics and level of funding of future navigation and outreach efforts.

While competitive and performance-based contracting might help mitigate agency problems, in fact many contracts – particularly for social services - are not

only non-competitive but also long-lasting and collaborative.[4] "Relational contracting," can engender more collaborative arrangements that limit contract implementation barriers (though establishing effective "relationships" does impose transaction costs (DeHoog, 1981; Johnston and Romzek, 2010). Contracting arrangements embedded in a set of service delivery organizations, may in fact function like networks (Johnston & Romzek, 2008).

The common mission shared by the ACA and many of the contracted navigator/assister organizations – the expansion of health insurance coverage to uninsured individuals – has the potential to alleviate network and contract management hurdles and to facilitate a more "relational," cooperative design of service delivery. In the following section, we use collaboration and networked governance concepts to further explore the ACA's implementation.

FRAMING ACA'S IMPLEMENTATION AS A COLLABORATIVE ENTERPRISE

Isett et al. (2011) define networks as "collections of government agencies, nonprofits, and for-profits that work together to provide a public good, service or "value" when a single public agency is unable to create the good or services in the desired quantities." [1] Networks are, "by definition…complex conglomerations of diverse organizations and individuals" (O'Leary and Bingham 2007, p.104). The foundational structure of networks – multiple organizations, sometimes from multiple levels of government and from different sectors – introduces a range of implementation hazards. The greatest challenges in networks have to do with goal conflict (O'Toole, 1989; Provan & Kenis, 2007; Provan & Milward, 2001), complexity (May, 2015; Romzek & Johnston, 2002) and potential competition over scarce resources (Guo & Acar, 2005; Johnston & Romzek, 2008). Each organization in the network brings its own unique set of interests, constraints, resources, and cultures to the table (Johnston & Romzek, 2010; O'Leary & Vij, 2012; Romzek & Johnston, 1999). These must be reconciled into a coherent system that works toward a set of shared over-arching goals.

The most successful networks are collaborative. Collaboration is enhanced by a prior history of cooperation among the network organizations, and effective incentives for participation (Ansell & Gash, 2007). Working toward a common goal does not obviate the need for defining network structure, designing incentives, and establishing trust to facilitate organizational learning and change.

Collaborative Network Structure: Building Capacity and Aligning Goals

[4] Collaborative governance refers to processes that "engage people constructively across the boundaries" of organization, government, and sector, for the purpose of achieving an objective that could not otherwise be met (Emerson et al 2012).

Networks and collaboration are primarily process-oriented systems (Barzelay, 2003; Rhodes & Murray, 2007). Network process features, such as "face-to-face dialogue, trust building, and the development of commitment and understanding" create "small wins" that deepen trust, commitment, and shared understanding" (Ansell and Gash, 2007, p. 543) and help create the added value and synergy that lead the network to deliver programs, with new capacities, that would be either impossible or less successful if left to a single organization.

Rhodes and Murray (2007) reinforce the collaboration process perspective by viewing networks through a "complex adaptive systems framework" that "allows for the emergence of structure out of the behavior and interaction of agents, which then influences the next iteration of agent/behavior/interaction" (p. 81). This framework emphasizes "an unfolding series of events…constrained by the interdependencies of agents…and the conditions that pre-existed the system's coming into being" and "observable path-dependencies in agent behavior" (p. 85). As Bryson notes, "the more [network] partners have interacted in positive ways in the past, the more social mechanisms will enable coordination and safeguard exchanges" (Bryson, Crosby, and Stone 2006, p.46).

Thus, a strategy of tapping into pre-existing relationships to accomplish an objective is consistent with leveraging the path-dependencies, repeated positive interactions, and other process elements that characterize successful collaborative systems. In highly complex environments, these systems therefore may have already created the infrastructures supportive of adaptation to changing conditions that emerge externally, among agents/actors in the network, in policies, and in service delivery strategies.

Networks exhibit a wide range of structures and centralization patterns: from *self-governing* networks, dominated by frequent informal interactions, to *lead organization* networks that are more centralized, operating under the direction of one coordinating agency which often holds the monopoly on network power, and to *network administrative organization* (NAO) networks in which a separate agency directs and oversees network activity (K. G. Provan & Kenis, 2007). The choice of governance structure may influence network effectiveness and collaboration quality. Provan and Milward (1995) concluded that in the comparatively formal mental health arena, the more centralized lead organization networks were most effective in achieving client outcomes.

Organizations and actors in networks use a variety of supplemental informal mechanisms that enhance both collaboration structures and successful service delivery (Amirkhanyan, 2008; Amirkhanyan, Kim, & Lambright, 2012). These include capitalizing on shared norms, relationship building, and the use of informal rewards, sanctions, information sharing, and mutual support to move the full network toward the service delivery objective (B. Romzek et al., 2014).

Collaboration in networks can reduce goal conflict through continual reinforcement of common missions and strategies that induce cooperation. As noted above, leveraging and strengthening pre-existing relationships can supplement these dynamics.

Evidence of Collaboration

Successful collaborations exhibit a set of observable features. Agranoff and McGuire (2001) argue that successful networks *activate* the skills, knowledge, and resources of network members, *frame* the operative rules that derive from relevant values and norms, *mobilize* organizations and coalitions toward a common objective, and *synthesize* the actors through coordination and shared goals by creating "conditions for favorable, productive interaction among network participants" (p.300), thereby aligning goals, reducing transaction costs, and enhancing trust and other collaborative synergies. Similarly, "first, second, and third-order effects" leverage collaborative networks' added value (Bryson et al., 2006). First-order effects create "social, intellectual, and political capital," second-order effects emerge when collaboration is established, but involve "joint action, joint learning….changes in practices, and changes in perceptions;" and third-order effects represent the synergistic outcomes associated with collaboration – "adaptation of services…new norms…generating social capital (p.51). Rogers and Weber (2010), studying environmental policy networks, conclude that the outcomes of successful collaboration include, in addition to program success, "improving public problem-solving capacity by taking advantage of the opportunities provided in these collaborative arrangements to tie together and collectively manage interdependent problems and policies" (p.548). This evidence of successful collaboration is by no means exhaustive, but it represents key conclusions in leading scholarship on the topic.

A major policy effort such as the ACA necessarily involved implementation through numerous actors across multiple organizations and jurisdictions. In the context of an easily measurable outcome – increased health insurance enrollments – we use the analytic lenses outlined above to explore the role, the scope, and the features of the law's formalized, performance-based contractual and intergovernmental arrangements, as well as more informal and collaborative inter-organizational relationships that were central to effective ACA implementation networks.

METHODS

Study Sites

We examined the ACA's implementation in a purposive sample of six states – Colorado, Connecticut, Kentucky, Maryland, Minnesota, and New York – drawn from the population of thirteen states that created their own online marketplaces. Additionally, in terms of the policy itself, our sampled states all expanded Medicaid eligibility as encouraged by the ACA. While limiting the generalizability of our observations, focusing on a set of states that share some key aspects of policy implementation allows us to go deeper into the implementation dynamics in that specific sub-set of jurisdictions. Focusing on these six states also helps achieve the level of comparability across cases conducive to identifying rival explanations (Yin, 2014). Our selection was also based on geographic diversity and, most importantly, on the variation in the initial assessments of performance of the exchanges, with the expectation that the performance of outreach and enrollment contracts might be related. The six sample states also vary on several dimensions such as size and socio-economic profile.

Connecticut, Kentucky, and New York have been widely judged as successful in terms of the initial launch of their marketplace exchanges. One year into the law's implementation, they experienced notable drops in the rates of uninsured. In terms of enrollments, one evaluation of enrollment effectiveness, provided by the Urban Institute's 2015 data on state enrollments as a percentage of Urban's projected levels, presents Colorado and Minnesota as performing below average, two years into implementation (Holohan et al., 2015). Both of these states experienced problems with the launches of their marketplace exchanges (but so did Maryland).

Both Colorado and Minnesota (problematic exchange launches) relied on quasi-governmental structures established through legislation, but so did Connecticut (launch success). Kentucky and New York, both successful in terms of take-up and exchange launch, incorporated their exchanges into the pre-existing state agencies through executive orders. Maryland struggled early on with a botched exchange launch, using a quasi-governmental approach mandated by the state legislation. Thus, it appears that, for this set of states, governance structures and enabling governmental mechanisms may not explain the variation in the enrollment take-up three years into implementation.

Of the three states that achieved take-up rates in excess of 30% by 2015 (see Table 1), only Maryland experienced early exchange problems, but state officials recovered quickly and performed above expectations by 2015.[5] These three states performed above average in terms of predicted take-up. So did New York, although its take-up was at 22% in 2015. This number exceeded expectations and may be attributable to the state's low pre-ACA rate of uninsured. Thus, exchange launch success appears to be a relevant, but not the most important predictor of subsequent

[5] Maryland quickly purchased computer code from Connecticut to completely re-tool its health exchange.

enrollment take-up and reflects positively on the contracting protocols used in these states. Conversely, in the two states with take-up rates below the expected levels – Colorado and Minnesota – the exchange launches were complicated, and contracting practices may have played a role. Three years into implementation, these two states had still not recovered from their early launch problems. Table 1 presents a snapshot of essential elements of our six states' ACA implementation structures and enrollment effectiveness. Table 2 provides more detailed state program descriptions.

[Tables 1 and 2 about here]

While at this stage of our research we are unable to comprehensively quantify the collaborative features of these states' implementation networks, we do observe that particularly deep community network partnerships in Kentucky and Maryland may help explain their comparative advantage in reaching eligible individuals. Colorado certainly also relied on these community connections, but the depth of ties did not emerge as strongly as the other two states. All six states reported that their implementation systems were highly complex, and Minnesota mentioned resource constraints with some frequency. While the most successful states, in terms of enrollment take-up three years into implementation (Connecticut, Kentucky, Maryland) clearly relied on leveraging community capacity and collaborative strategies, these elements, strongest in our interview data in Kentucky and Maryland, helped to raise these states to the take-up levels exhibited by Connecticut through its leading early exchange performance.

Interview Strategy and Instrument

While we included deductive elements in our data collection efforts (in the form of questions whose answers we expect to correlate with respondent and external perceptions of overall effectiveness), our research strategy is primarily inductive by nature. As suggested by Agranoff and Radin (1991), we follow a multiple-case study design that is foundational to public management scholarship (Frederickson & Frederickson, 2006; Radin & Romzek, 1996; Sandfort, 2000). Within each state, we sought to maximize the range of perspectives by reaching out to health exchange staff, state employees representing departments that interfaced with the exchange, organizations that contracted with (or received grants from) the states to deliver navigation and outreach services, as well as subcontractor agencies, and advocacy organizations operating in legislative and program utilization venues. Within each state, we employed a snowball sampling strategy and completed 40 interviews across the 6 states. While the snowball sampling strategy precluded us from identifying an exhaustive list of actors necessary for conducting network analysis, this strategy can help identify the key features, successes and failures of implementation, as reported by a broad range of participants. Interview data were

collected between December 2015 and late summer 2016. All interviews were recorded, transcribed, extracted, coded, and analyzed using NVivo10. Table 3 provides details on our respondents in each state.

[Table 3 about here]

The interview instrument consists of open-ended questions designed to capture the perspectives of each respondent about the implementation of ACA navigation and outreach services within the context of the broader ACA implementation experience in their state (see Appendix A). The instrument is built around key research questions as described in the introduction, such as the issues related to policy implementation, contracting, and collaborative service delivery.

Data Analysis

All qualitative data were imported to and analyzed in QSR NVivo10. The interviews were coded and analyzed using a mix of deductive and inductive strategies. We started by reading and discussing all 40 interviews and identifying the initial set of codes. This was done by the entire research team of four co-authors. As the analysis was conducted using the initial set of codes, additional codes and sub-codes were added to reflect any emergent themes within the preliminary codes. The identification and interpretation of the key themes is grounded heavily in the interview data, and less so in the past literature. In the presentation of findings, we describe the main themes using quotes and summary statements. When appropriate, we also semi-quantify these themes by reporting their prevalence.

FINDINGS

The patterns that emerge from our data are organized by key aspects of implementation and collaboration described in the framework above. We begin with the policy context – in particular, the roles of politics and resources. We then turn to the role of structure including the types of contracting and oversight regimes we encountered in our sample. This is followed by the patterns related to the goals – particularly, goal congruence and goal complexity – which are fundamental drivers of network collaboration. Next, we assess for the presence of elements of collaborative effectiveness - network activation, mobilization, and coordination (as emphasized by Agranoff and McGuire (2001)) and the leveraging of community capacity and pre-existing relationships to create new social capital (Bryson et al., 2006) that adds value to implementation efforts. Essential to enhanced capacity and social capital are the roles of trust and commitment in fostering the joint efforts that emerged in our data.

Policy Context

Policy context often holds the key to the challenges and successes of implementation. Contextual policy and political factors associated with implementation of the ACA were referred to in the majority of our interviews (n=28 or 72%). Several strong themes emerged in the interview data. First, positive political support for the program from state and local politicians was highlighted as a notable aid in outreach and enrollment work. As one respondent remarked, "the majority of legislators [in the state] were very supportive, and I used that as leverage because constituents wanted to see them, they wanted to see constituents, so I used that as an opportunity to increase enrollment efforts" (CT7). As a corollary proposition, one respondent described how her agency was particularly sensitive to responding to requests from politicians to address problems their constituents were experiencing. In her words, these individuals "shoot their way to the top of the list of our people to help" (MD4).

At the same time, contested politics was also a common theme, even though all of the states in our sample opted both to expand Medicaid and implement their own exchanges. Political friction occurred at both the state and local level. As one interviewee described her experience working with state legislators,

> "I had legislators telling me "Why is [your organization] going to lift a finger to prop up this failed law?". And we were in a very difficult spot, because the law is the law, and we are a not-for-profit organization with a mission that is making a healthy difference for our members…Every step along the way – and I don't want to paint a broad brush, it wasn't just all Republicans – there was a big group that was committed to undermining the law, and we were caught in the middle of that. And so were many, many people across the state … and the country. So that was a really big deal here, just as it was nationally" (MN7).

In Kentucky, a conscious effort was made to mask the association between the state exchange and the ACA in marketing, outreach and enrollment activities, given the broad unpopularity of Obamacare in that state. This strategy proved successful in generating support for the Kentucky program, albeit not without consequences. As one respondent observed,

> "…the fact that we did such a good job of branding our work as being entirely a Kentucky program and really disconnecting it from the Affordable Care Act, I wonder if that has had negative consequences that we wouldn't have expected because people don't associate it with the Affordable Care Act" (KY5)."

Political contention at the local/county level surfaced as an important factor driving the level of effort and resources expended on ACA navigation and outreach services. This phenomenon was reflected in county variations in the "willingness

to invest, to put resources into writing a grant, and having an assistance site there, partnering with local community partners, education people about the ACA" (CO8).

In addition to politics, resource adequacy emerged as an important element of the policy context in 32 (82%) of our interviews. While some respondents considered outreach and enrollment service funding to be adequate, others averred that the demand for services far exceeded the supply, and that more could have been achieved with additional funding. As a corollary to this view, the inadequacy of reimbursement for groups assisting people with enrollment was stressed repeatedly:

> "So $6,000 [award amount] didn't even begin to cover the number of hours that the individual assister spent conducting outreach in the field, the number of what marketing would call encounters that … took place to complete the enrollment process. So, assister organizations were exhausted, they were frustrated. They were nevertheless committed. We had no assister organization pull out of their contract for that reason. But nearly every report at the end of the enrollment period indicated that this was not enough money" (CT6).

The uneven distribution of resources between the Qualified Health Plan (QHP) program and Medicaid was an important factor as well. In Minnesota the difference in the reimbursement fee paid for assistance with enrollment in Medicaid ($25) versus a QHP ($70) was widely criticized as being unfair, especially in light of the fact that many people in hard-to-reach communities, requiring intensive assistance, "qualify for Medicaid and when they qualify for Medicaid, we get reimbursed only $25 per person for application" (MN4).

Notably, most respondents perceived navigation and outreach not as a one-off event but as a continuous effort. As the initial federal grants expired and the funds available to exchanges for navigation and outreach activities sharply declined, services and capacity had to be scaled back despite the continuing need for them. In response to the declining navigation and outreach funding, exchanges have focused resources on bolstering technological tools and investing in the capabilities of their call centers, and moved away from funding community-based activities. This reliance on technology and shift toward more centralized management of navigation and outreach was decried by some as ill advised:

> "I think [the exchange] was really working hard to make a case as to why in-person assisters are not needed because they had the storefronts and they had the call center, right, and people can also go online and yes the bulk of the enrolment did happen through the call center. But that's from people who are, our enrolments were very different because we were reaching population that [are] just very hard to reach groups. The Vietnamese people; we had Laotian; we had the Arabic community; the Arabic speaking community. Those are groups that didn't, weren't trying to go to

> the call center. After, they closed the doors on the program, because the federal money was not available" (CT5).

In the face of uncertain funding for navigation and outreach among grantees, the difficulty of managing organizational budgets and retaining staff emerged as a key concern. Due to gaps between contracts, the contract process with the exchange was potentially problematic, resulting in weeks in which "you have nothing to do with your staff" and "you can't tell them, 'Okay, you have to go home for the next 2-3 weeks until the next time starts'" (MN4).

The ACA policy context was therefore shaped by high levels of uncertainty. Over time, however, the nature of uncertainty has shifted. When discussing the initial enrollment, respondents cited the shifting regulatory and rule-making processes within very narrow time frames as major sources of uncertainty. Following the expiration of federal startup grants for navigation services after the second enrollment period, uncertainty over the levels of funding – and their impact on the scope and quality of navigation and outreach services – became significant sources of concern. Finally, as the November 2016 general election drew nearer, interviewees reflected on the macro level concerns – specifically, the uncertain viability of the ACA, given one candidate's pledge to abolish it. More uncertainty was generated by the decisions of many major insurance carriers, across multiple markets, to exit the ACA marketplace for individual insurance.

To summarize, the patterns we find in our data suggest commonality across these states with regard to high levels of political uncertainty and its potential impact on resource adequacy. Uncertainty aside, political support seemed to be highest in Connecticut and New York – two states that performed well in terms of take-up of their eligible populations.

We observed that respondents were proactive in framing the policy and its implementation in ways that minimized political conflict and appealed to individuals across party lines. In short, variations on policy dimensions across the state were real but somewhat muted. The policy context appears to be only moderately related to the variation in states' goal achievement with regard to enrolling eligible individuals.

Structural Aspects of Collaborative Activity

A key line of inquiry for this study is to better understand the formal and informal inter-organizational arrangements in public-private navigation and enrollment efforts. Nearly all respondents (37 or 95%) delved into specific aspects of the collaborative structures supporting ACA navigation and enrollment. Perhaps the most salient characteristic common to all the states in our study was one that commonly trips up implementation: structural complexity. Respondents often

mentioned the number and breadth of entities participating in the states' implementation networks. In addition to central marketplace exchange staff, network actors included state Medicaid agencies, county Medicaid agencies, local public health departments, insurance brokers and agents, community-based organizations, foundations, and private firms providing call center, marketing, advertising, and program management services.

Not surprisingly, given the multiplicity of actors, network coordination presented a major implementation challenge. In particular, the first open enrollment period was characterized by struggles identifying "who should be doing what and how" and what organization "was appropriate to go to for help" (CO7). The actors within each state were actively engaging in the activities emphasized by Agranoff and McGuire (2001) in their studies of networks: *framing* (creating operative rules), *mobilizing* (motivating), *and synthesizing* (coordinating). The structures of the state implementation systems consisted of both formal contracts and informal relationships among organizations charged with outreach and assistance to individuals eligible to enroll in insurance coverage.

A common strategy involved creating some level of network management through designation of the state ACA exchange to function as a coordinating organization. Under this scenario, the state's exchange would funnel resources, through grants and contracts, to organizations in the community to provide navigation and outreach service. This structure resembles the "lead organization" strategy evaluated as particularly successful in Provan and Milward's (1995) study of effective community mental health networks. The provision of services on the ground was sometimes managed at the regional level, through intermediary umbrella organizations that were awarded grants by the exchange, based on a formal RFP. As described by one exchange official:

> "One of the central criteria on … selecting which entities would be given these grants awards to be the umbrella organizations in each region of the state was the extent to which they could show that they had partnerships and relationships with other smaller community-based organizations within their region that were targeted, more targeted even for certain populations that we are trying to reach.
> So, I think that, for the most part, that the theory behind that has played out successfully, you know, we really have benefited from the local connections that Connector entities have and their knowledge of their regions that, you know, they have a familiarity with people and their relationship and they have a relationship that we wouldn't have been able to have on our level." (MD1)

Thus, selection criteria incorporated leveraging of pre-existing relationships to build capacity and minimize transaction costs, consistent with strategies for collaborative effectiveness (Bryson, Crosby, and Stone, 2006). In addition to managing navigation services for a specific region or target population, grantees

were essential sources of expertise and technical knowledge. In the words of one exchange staff member, "[t]he function and the role of the navigators were to provide mentoring, technical assistance, organizing strategy to help assister organizations overcome barriers, as well as conduct individual enrollments" (CT6).

In general, respondents viewed decentralized structural features and delegation of day-to-day operational management to regional grantees as a source of strength, though not without pitfalls, as one interviewee noted:

> "…It's great that they've contracted these local agencies and we can really be connected with the folks in the communities. But I think, it does occasionally make for a situation where [the exchange] is disconnected from a consumer or a consumer experience in ways that we try really hard to make sure they can hear, but we occasionally experience disconnect" (MN5).

Similarly, as described by another respondent, the network configuration requires

> "… communication in every direction – up, down, sideways, backwards and inside out. If a policy gets made at the board level that impacts the consumer assistance and the connector entity, that may go to the staff person at the exchange, who is tasked with communicating that, and it may go then to the head of the connector entity. But those connector entities…are made of not just one organization but then they fan out into smaller community based organizations around every county. So, that policy piece may go to the staff person, but it doesn't get down in a way that is really reusable to the folks that are working on the ground" (MD 7).

In other words, the coordination, or *synthesizing* function (Agranoff & McGuire, 2001) was somewhat undercut by a common challenge in collaborations – effective information sharing and related transaction costs. We note, however, that despite these issues, respondents were mostly supportive of states' decentralized implementation strategies.

In terms of incentives, grantees and contractors typically had specific enrollment and outreach performance targets written into their agreements, but in most cases, these were not linked to specific bonuses or penalties, nor were the targets differentiated by type of plan eligibility (i.e., QHP vs. Medicaid). One exception was described by an interviewee from Kentucky:

> "they [the contractors] don't get paid by the application, because a big part of their job is education, but they have a range of goals to meet in terms of how they're doing. Then, there is a 10% bonus, and a 10% penalty if they're not within what their numbers should be. Then we had, there were a lot of specifics in there in terms of what they're supposed to do, and how they're supposed to do it, and then how they're supposed to write a report back to us. For example, if they go to a fair and

> festival, they need to send us a picture of what their booth looked like or what it is that they did. We didn't want them to be saying you know we were at the Johnson County Fair, and then it was like one person was there handing out flyers versus you know what we were expecting which is that they would have a table and give out materials" (KY4).

Kentucky, therefore, used performance-based contracting strategies to enhance accountability, incorporating rewards and sanctions, but also monitored closely by requiring verification of required outreach and enrollment activities.

Overall, formal oversight and accountability was vested in part through exchange (lead organization) reviews and re-tendering of navigator grants and contracts. Some states (such as Minnesota) opted to do this on a yearly basis, while other states awarded grants for 2 or 3-year periods. Monthly reporting to the exchange was a common oversight mechanism mentioned in our interviews. One respondent from Connecticut described a strategy that combined a formal financial component with an informal moral suasion element:

> "So, anyway, I think for some people they just thought I'll take this money and nobody will ever know that I'm not doing anything. But we were very serious, and we would say things to people who weren't doing anything like, you are stealing money from poor people. It's hard to answer that. Don't give me that, get your work done. Because we could have given the contract to someone else, and there are people without health insurance, let's get real about this. We found that most people really wanted to do it, they just were stuck, and we helped them get unstuck, and some people just didn't want to do anything and they didn't do anything. We stood on our heads and we did as much as we, could but somebody doesn't want to do anything. So, we held back $1,000 of their contract and we didn't pay the last thousand. So, we paid them $5,000 and we held back $1,000. So, some people didn't get the last thousand, and they were sort of mad but, you know, it's life. But we were very closed on it, and we published the report on who did finish the work and who didn't." (CT3)

This strategy tapped into common network organizations' goals as incentives, thereby reducing transaction and oversight costs, but when unsuccessful, resorted to the more traditional (and decidedly less collaborative) formal, transaction-based contracting techniques, including the imposition of penalties and the invocation of reputational threats.

Thus, the structures of these implementation systems, for the most part, were similar across states with regard to their high structural complexity, strongly decentralized approaches, and adoption of a lead organization model (Provan & Milward, 1995). Contracting was widely used, and included performance targets, but only two states – Kentucky and Connecticut – reported adopting binding

contractor performance rewards or penalties; each did especially well in terms of meeting enrollment expectations.

Goal Simplicity and Clarity

With a new major policy introduced and multiple actors playing a wide range of roles, perceptions of policy goals are important to understanding the strategies and outcomes. Respondents referred to goals in 18 (46%) of the interviews. Reduction in the number of uninsured persons – an easily measurable policy achievement - was the most salient goal articulated by many respondents. Several respondents went deeper, citing the issues of affordability, another central goal of the ACA, as a constraint on reducing the number of uninsured or even retaining current insurance enrollees. A core challenge was described by one respondent:

> "… how do we figure out the system that gets at reducing the people who don't have health insurance, which is exactly what we are doing now, but also offers options that are affordable to people? I think that's always going to be the challenge, and moving forward if there's a way we could figure out the system where people can go on, like they can right now on MNsure, search through these different health plans and say, "Okay, this works really well for me I'm going to buy this one," and they do, and then the following year [the cost] doesn't go up by 100% premium." (MN4).

Further, a need to address the remaining disparities in insurance coverage and access to care, based on racial, ethnic, cultural and language barriers, was cited as an issue in multiple interviews. A Minnesota official suggested that the incentive structure for navigators be modified to address this:

> "... there was a big push to make this navigator program work for populations that are not entering through the traditional ways. You have to make sure you are reaching our populations of color, our native populations. And all of these populations continue to show the greatest disparities, whether they are insured or not. There wasn't … there was not a lot (in the first year) of thought given to who and what organizations serve which populations, and do we have enough to serve, are we making a dent, are we making sure they are well trained to reach populations. So, I don't think there was enough thought to that. I also don't think there was enough thought given to how to alter the payment structure to reach those populations… I think that navigators needed to be rewarded in a different way to make sure they were reaching those populations of color. They should have had a different pay structure for reaching the populations that we said were important for us to reach" (MN8).

Our respondents also frequently referred to the goal of educating people on being smart consumers of health insurance beyond simply enrolling in coverage.

The importance of health insurance literacy was emphasized as a critical element of retention and successful transition between different types of insurance coverage (e.g., moving from Medicaid to QHP or employer-sponsored plan):

> "So, we've got folks who have received coverage for the first time through Medicaid under the expansion and now … perhaps they are able to purchase private health insurance. They've got another paying job, they got an extra shift, that sort of thing, and making sure that folks know how to navigate health insurance, which we all know is not easy, no matter what your education level is…We're really trying to focus on how can we … at a Medicaid level, help them understand how to navigate health insurance and what the value of insurance is, so that when they do go up and off Medicaid into private insurance, they're better consumers of health insurance in general. That is something we see as a challenge" (CO7).

Importantly, trust, commitment, and shared norms, interacting with goal agreement, appear to be central to the implementation of ACA across the sampled states, as reported in 11 (28%) interviews. Our respondents identified a range of factors positively contributing to the development of trust. These included operational and stakeholder transparency, cooperation between navigator organizations to balance workloads, exchange efforts to foster a sense of connectedness among navigator organizations, and the positive experiences borne of navigator-broker cooperation.

On the negative side, the partisan political divide over the ACA and an initial lack of commitment to sharing information and coordinating activities with Medicaid agencies by state exchanges were cited as impediments to the development of trust. One commonly noted drawback of the configuration of navigation and outreach services was the limitation of navigators to online access of applications initiated by consumers. The conflict between the twin goals of ensuring privacy protections of consumers and enabling access to enrollment services through multiple venues emerged as a common theme. Another example of goal conflict surfaced in the prohibition against navigators offering advice on plan selection, based on the circumstances of the applicant. Although this restriction is in the statute to obviate the possibility of coercion on the part of navigators, it limits their ability to provide guidance, which many applicants deem desirable.

Overall, we observed a substantial amount of congruence in the goals discussed the by many stakeholders that we interviewed, despite varying levels of goal conflict that surfaced during the ACA implementation. Most respondents conceptualized their goals primarily in terms of higher enrollments, with the caveats of ensuring affordability and informed decision-making. With regards to the central focus of the ACA, we observed no substantial or systematic evidence of perceived or reported goal ambiguity or any notable divergence of goals across

multiple parties. This, among many other factors, may have shaped the implementation of the law in these states.

Evidence of Successful Collaboration

Having just gone through the process of implementing a major new law, 18 (46%) of our respondents explicitly referred to various elements essential to effective network collaboration as highlighted in prior research. These include establishing processes and mechanisms for *framing* rules, *mobilizing* toward a common objective, and *synthesizing* with coordination and shared goals (Agranoff & McGuire, 2001). Several respondents commented on the importance of broad-based stakeholder meetings in building support for the exchanges in general, and navigation and outreach in particular. As described by one interviewee, the effort

> "was very much a broad-based partnership in terms of planning and building how this… how Colorado's exchange was actually implemented. It really was designed to be a very Colorado-specific effort. And so, that what we created was designed to really reflect what the stakeholders wanted and the uniqueness of the state. And, I really think that that was something that we did very well and that that was reflected also in how the navigator program and the outreach work was established, as well as many of the different operational details of the exchange" (CO5).

Catalysts for the mobilization of organizational and other resources sometimes derived from opportunities – for example, filling a void in the stewardship of a state IT system instrumental to the implementation of the ACA – and from cross-cutting affiliations of the key actors. One example of the latter is a Medicaid agency that was able to leverage the executive director's profession as a nurse to mobilize "a whole network of nurses who are out in the community, not just the office… They helped us get the word out. And we gave them tools to do that" (CO7). Similarly, exchange board ties to key state entities – for example, the director of the state agency overseeing Medicaid – were also cited as helping to secure "strong partnerships with those agencies" that "were already heavily involved in health care, health eligibility, health insurance, health programs, and health access" (MD6).

Another collaborative strategy described by respondents was to tap into the knowledge and expertise of individuals conducting navigation and outreach in order to support the efforts of those who were new to the venture or who were experiencing problems. This type of assistance came in two basic forms: in-person support and technological/communication tools. An example of the former is described by one respondent from Connecticut:

> So, one of the biggest things that we did was we got the assisters together in little clusters and we started having them come, we facilitated meetings, monthly meetings where we talked about strategies, we talked about the cases, things like elevator pitches, how to do it, how to get out there, how to touch the people that you need to touch because you couldn't really be passive if you're doing outreach…Then the navigators worked with the assisters and they started planning community enrolment affairs. So, they would … have a fair at the public library in New Haven. They would have one in this housing development that was different. For example, the housing development one needed more Spanish speaking assisters, and so we started to coordinate their efforts" (CT5).

An example of an enabling technological communication tool was the Assistor Resource Center (ARC), a website for navigators and certified application counselors in Minnesota to share information, with a dedicated support staff to assist in troubleshooting enrollment problems. This is supplemented by a monthly call for navigators, coordinated by the exchange, to disseminate information and "hear from navigators, hear about what's working, what the struggles are" (MN5).

Leveraging community capacity by partnering with the existing community networks was stressed by respondents in 25 (64%) of interviews as an essential component to the success of getting individuals enrolled in health insurance:

> "What happened was, it appears to me that there were these very large networks of organizations that … pre-existed the ACA or kind of advocacy groups for coverage. We've done some coverage and we've done some coverage expansion. So, there were some groups that I think had already formed themselves and mobilized to try and move those earlier efforts forward... Once the ACA passed and all these funds started coming in to the state, they essentially re-mobilized the networks that were already in place" (CO2)

Some respondents described the state environment as being supportive of nonprofits in general, with an established pattern of collaboration where people are "very open to getting themselves to work on coalitions and work together and be constructive" (MN3). Among the types of networks accessed, pre-existing Medicaid assistance networks were referenced by several respondents as an important resource, given their prior experience enrolling low income populations in health insurance programs. Advocacy networks were also cited as key players in shaping the delivery of navigation and outreach services. In a similar vein, many respondents remarked upon the importance of connecting with existing community-based organizations working with specific populations that were likely to qualify for Medicaid or ACPTS, such as immigrants. Community institutions were also noted as key conduits for outreach, "particularly if their missions had some type of social justice component to it" (MD3).

Many of these pre-existing networks relied on connections with public health departments, local libraries, churches, and small businesses. They formed ties with community leaders, elected officials, and citizen groups. And, they embraced locations in which potentially eligible individuals were comfortable, and where trust had already been established through community practices directed at reducing health disparities – locations such as barbershops and spas, where research has demonstrated success in public health outreach (Browne et al., 2006). A prominent example is the Black Barbershop Health Outreach Program, which has focused on "efforts in places outside of traditional clinical and community settings such as the barbershop has shown promise for ameliorating [health] disparities" for diseases such as colon cancer and hypertension (Releford et al., 2010; p.185).[6] Similarly, "beauty salons represent a promising setting for maximizing reach, reinforcement, and the impact of public health interventions aimed at addressing health disparities among African American women" (Linnan & Ferguson, 2007).

In addition to tapping into existing community networks and resources, states worked to cultivate and develop new sources of community capacity. One interviewee described a concerted strategy to identify key individuals, known to community members, to help create micro-groups to get different groups "to work together who had never worked together before," with the aim of customizing outreach (CT3). Another respondent described how the exchange targeted community leaders, including elected officials, "who represented hundreds if not thousands of people within their community," and "trained them on what the ACA is … and how they can help spread the word" (CT4).

Although public and nonprofit organizations were more likely to be leveraged in navigation and outreach, private-sector resources were also instrumental to the effort. Brokers and insurance agents were the most common sources of private sector participation with ACA navigation and outreach. An example of cooperation between brokers and navigators is the Minnesota Preferred Broker Program, in which navigators co-locate in a broker's office during open enrollment. In the words of one respondent, this approach fuses different areas of expertise in a single location, since "brokers don't necessarily want to deal with Medicaid and navigators don't necessarily know how to answer some of the questions that come up in a QHP application" (MN1). Local businesses were also recruited to disseminate enrollment information directly to workers, particularly among employers who hired part-time staff, such as the barbershops and spas referenced above, as well as fast food establishments and small retailers.

Most of these states' network groups were committed to the outreach enterprise in part because they shared a common ACA goal – to increase health

[6] The Black Barbershop Health Outreach Program has been used successfully to reach thousands of African-American men through community-based health screening and other preventive programs (Releford et al., 2010).

insurance coverage. The community-based strategy helped to simplify a highly complex implementation task. While elongated chains of accountability can impede implementation, in this case, the combination of pre-existing relationships, which helped to build or solidify trust, combined with common goals and extensive capacity to reach into communities, mitigated transaction costs and fostered implementation.

In essence, the framing, mobilizing, and synthesizing efforts we observed capitalized on established personal and inter-organizational relationships, as well as professional ties. These efforts tapped into the existing expertise of local communities and relied on community-based and online vehicles to bring people together to inform, strategize, exchange information, and motivate the potential collaborators. These efforts may have helped build extra support for the policy, identify additional partners, and reduce informational asymmetries that may have affected the next stages of implementation. In addition, these strategies achieved the first, second, and third-order effects referenced by Bryson, Crosby, and Stone (2006) as necessary for effective collaboration, generating social capital, service adaptation, and joint action and learning. The synergistic elements of these collaborative efforts appear to have generated added value – delivering, as networks of organizations and individuals, service levels and quality *beyond what could have otherwise materialized.*

DISCUSSION AND CONCLUSION

Much of the prior discussion about the implementation of the ACA has focused on the failures related to information technology. While the marketplace is an important component of the law, a broader discussion of implementation – particularly of outreach and enrollment services – can add to our understanding of how the law has been executed and how similar laws may be best executed in the future. Much can be learned from the work of dozens of agencies, hundreds of organizations, and thousands of individuals involved in the implementation effort. This paper attempts to shed light on this central part of ACA implementation by examining partnerships that may have facilitated increased rates insured populations in a sample of six states.

In this sample of states, the implementation challenges were more or less commonly shared: complexity of the intergovernmental and inter-sectoral structures, organizations, and actors; resource constraints; political and policy uncertainty; and the use of market mechanisms – contracts and their attendant accountability challenges, all increased the potential for serious impediments to executing the law. But, perhaps most importantly, in all states under consideration, we observed elements of collaboration effectiveness stressed in the prevailing theories. The states in our sample were able to use contracts to create extensive

community-based networks that were central to their implementation efforts. These collaborative systems were built on pre-existing relationships. They reached deep into communities, aligned goals so that the simplicity of purpose trumped complexity, and achieved collective synergies that generated social capital, adaptation, joint learning, and new capacities. The activation, mobilization, synthesis, and coordination elements needed for effective collaboration emerged as strong themes in our data (Agranoff &McGuire, 2001), as well as the added value needed to achieve what would not have been achieved without the network (Bryson, Crosby & Stone, 2006). Trust, commitment, shared norms helped the states move toward the common goal of increasing insurance coverage and reduce the fallout from unavoidable sub-goal conflicts.

While federal resources were instrumental to states' implementation efforts, the uncertainty of future funding pushed the implementers to search for solutions and to innovate. We observed successful efforts to build on existing local expertise and capacity, capitalizing on the strengths of local organizations and actors. When needed, states also pursued their own technological solutions. Finally, we saw evidence of adaptation and learning among key participants in implementation.

The six states varied in their performance as measured by "taking up" eligible enrollees. We speculate that the effectiveness of the first market exchange launches may be important in explaining take-up in these states. Exchange governance structures and the legal mechanisms that established them appear to be less useful in explaining the variation in take-up. With this analysis of interview data, we suggest that two states with particularly successful and deep community ties embedded into their implementation systems – Kentucky and Maryland - were able to achieve levels of take-up consistent with Connecticut – the state that led the pack in terms of exchange launch success.

These findings suggest that the implementation of social programs could in the future be facilitated by adopting simple but explicitly decentralized, goal-focused strategies that draw on established local networks of expertise and commitment, and that the use those networks and their individual members, especially those who are trusted in their communities, to break down barriers to program participation among targeted populations. Despite the common implementation problems related to structural complexity, political uncertainty, and resource concerns, what we observed in these admittedly policy-supportive states indicates that *emphasizing collaborative strategies*, and *mobilizing community resources and organizations with the closest ties to the targeted enrollees*, can mitigate implementation obstacles. The states that emerged as most successful on these and other collaborative dimensions also enrolled comparatively high percentages of their ACA-eligible populations.

Our findings are tempered by the limitations of our snowball sample strategy within the six states. Interviewees were not randomly selected from the

complete pool of actors involved in their states' implementation of the ACA; therefore, selection bias is a concern. Generalizability is also an issue, though limiting the sample to the states that implemented health exchanges provides for more depth and greater comparability in identifying sources of variation in our findings (Yin, 2014). Our conclusions are meant to be suggestive and not conclusive. The next steps in this research should build on this work by formally identifying and testing hypotheses, especially as related to collaborative networks, across a wider range of states and/or local settings. Furthermore, new data on the post-2016 years is needed that can shed light on the extent to which the early successes in these states were sustained (or not). Despite the limitations of this research, it contributes to our understanding of the underlying dynamics associated with the implementation of the ACA. It provides insight into how states developed complex outreach and enrollment systems that performed well despite of a wide range of contextual challenges.

Table 1. Characteristics of Exchanges

State	Name	Creation Date	Mechanism	Governance Structure	Exchange Launch	Uninsured Rate			Take-Up Rate*	Enrollment Success**
						2013	2014	2015		
CO	Connect for Care Colorado	07/2011	Legislation	Quasi-govt.	Problematic	14%	13%	10%	22%	Below
CT	Access Health CT	08/2011	Legislation	Quasi-govt.	Excellent	12%	8%	7%	35%	Above
KY	Kentucky Health Benefit Exchange	08/2012	Executive Order	Within State Agency	Very Good	16%	8%	7%	30%	Above
MD	Maryland Health Benefit Exchange	03/2011	Legislation	Quasi-govt.	Problematic	13%	6%	7%	34%	Above
MN	MNSure	03/2013	Legislation	Quasi-govt.	Problematic	8%	8%	7%	22%	Below
NY	New York Health Benefit Exchange	04/2012	Executive Order	Within State Agency	Very Good	11%	9%	8%	22%	Above

* This information is valid as of March 2016. Data include individuals who have enrolled in a Marketplace plan, have paid their first month's premium ("effectuated" enrollment), and *who have an active policy. The take-up rate is calculated based on potential marketplace enrollees; this includes all individuals eligible for tax credits as well as other legally-residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate excludes uninsured individuals with incomes below the poverty level who live in states that elected not to expand the Medicaid program. These individuals are not eligible for financial assistance and are unlikely to have the resources to purchase coverage in the Marketplace.

Source: Kaiser Family Foundation. (2015). Marketplace Enrollment as a Share of the Potential Marketplace Population Kaiser Family Foundation. Retrieved November 8, 2017, from https://www.kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

**Compared to Urban Institute's Enrollment Projections as of 2015 (Holahan et al., 2015)

Table 2. The Details of State Implementation Structures

Implementation Structure Details
COLORADO. Colorado's market exchange was established by state law in 2011.[78] Although created as quasigovernmental agency, the exchange was registered as an independent nonprofit entity in March 2012. Connect for Health Colorado is governed by a Board of Directors appointed by the governor and the state majority and minority leaders in the Colorado legislature. Navigation and outreach services are outsourced to a variety of organizations in the community. The constellation of organizations connected to this effort are commonly referred to as the 'assistance network' while navigators are known as 'health coverage guides'. Colorado's marketplace exchange launch was complicated by issues related to its use of funds
CONNECTICUT. In 2011, Connecticut adopted legislation authorizing the creation of market exchange. Known as Access Health CT, Connecticut's exchange functions as a quasi-governmental entity. Its governance structure consists of a 14-member governing board, headed by the lieutenant governor. The board members are selected according to their positions in state government, including the commissioner of social services, secretary of policy and management, and the state healthcare advocate, or are appointed by elected officials (specifically, the governor, and the majority and minority leaders of the Connecticut House and Senate). Connecticut's exchange code has been viewed as a model and acquired by other states with failed launches, including Maryland.
KENTUCKY. In 2012, Governor Steven L. Beshear (D) issued Executive Order 587 establishing the Kentucky Health Benefit Exchange (KHBE) within the Cabinet for Health and Family Services. In 2013, the state announced that its online Marketplace would be called Kynect. Navigators and in-person assisters are known as "Kynectors." Kentucky's exchange launch has been associated with few concerns, and its success has been attributed in part to its simplicity. Following the 2015 election of Republican Governor Matt Bevin, whose election campaign platform included promises to dismantle Kynect and the state's Medicaid expansion, the future of the state exchange is unclear.
MARYLAND. In 2011, Governor Martin O'Malley (D) signed SB 182/HB 166 into law establishing the Maryland Health Benefit Exchange (MBHE). In August 2012, the state announced that the name for the new insurance Marketplace would be Maryland Health Connection. The law defines the MBHE as a quasi-governmental organization, specifically, a "public corporation and independent unit of state government." The MHBE is governed by a nine-member board, including the Executive Director of Maryland's Health Care Commission as the Chair, Secretary of Health and Mental Hygiene, Commissioner of Insurance, and six members appointed by the Governor

[7] The other seven state-based exchanges are in California, District of Columbia, Idaho, Massachusetts, Rhode Island, Vermont, and Washington.

[8] The name of the exchange was changed from Colorado Health Benefit Exchange to Connect for Health Colorado in March 2013.

and with consent from the Senate. Maryland's exchange launch was associated with highly visible problems for the consumers, similar in many ways the issues of the federal exchange, in part due to its ambitious plan to integrate ACA and Medicaid data systems.
MINNESOTA. Minnesota's market exchange, MNSure, was created through legislation passed in 2013. MNSure is a state entity governed by a Board of Directors appointed by the governor and confirmed by the Minnesota House and Senate. Members serve four-year terms and the composition of the board is subject to requirements related to geographical and area-of-expertise representation. Minnesota's exchange launch encountered problems early on.
NEW YORK. The New York Health Benefit Exchange (NYHBE) was created by Executive Order within the NY Department of Health. The Exchange was given the authority to work in conjunction with the Department of Financial Services and other agencies to carry out the requirements of the ACA. Although the Executive Order did not create an independent governing board for the exchange, it established regional advisory committees, consisting of consumer advocates, small business representatives, health care providers, agents, brokers, insurers, labor organizations, and other stakeholders, to advise and provide recommendations on Exchange operations. Over 180 members were appointed to five regional advisory committees. New York's exchange launch has been seen as quite successful.

Sources for Tables 1 and 2: Kaiser Family Foundation reports (the rates of uninsured retrieved from http://kaiserf.am/2eNPk54; Rockerfeller Institute of Government, ACA Implementation Research Network reports

Table 3. Interview Respondent by Organization Type

	State agency	**Contractor**	**Other***	**Totals by state**
Colorado	4	4	0	8
Connecticut	4	3	1	8
Kentucky	1	3	1	5
Maryland	3	3	1	7
Minnesota	2	6	1	9
New York**	0	2	1	3
Totals by type	**14**	**21**	**5**	**40**

*Other" includes advocacy organizations and academic researchers who authored Rockefeller Center-sponsored studies of states' ACA implementation approaches
**New York's low response rate owes to a rule placed on contractors by the state that restricts them from speaking to external entities regarding their work for the exchange. Repeated attempts to interview respondents from contracting organizations and state agencies, including the exchange, were unsuccessful. Our findings section includes observations from New York respondents when possible.

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Appendix A. Interview Instrument.

Note to the Interviewer. Read: "Thank you for agreeing to participate in our study."
Turn on the voice recorder and identify interview ID and location, e.g., "This is Washington DC interview number one."
Begin the interview.

1. I would like to begin by asking about your agency (for nonprofit respondents, use "organization"). What does your agency (organization) do? What is its role in the implementation and operation of the ACA?
2. What is your position and your role with respect to the implementation of the ACA?
3. Please describe your state's experience with the ACA. We are especially interested in your view of the strengths and weaknesses of your ACA navigation and outreach services.
   Probe: What makes your state's experience unique?
4. Can you describe your state's administrative or management infrastructure for ACA navigation and outreach?

   a. Has the state conducted (or have plans to conduct) any customer satisfaction surveys that you are aware of?
5. Some states tend to contract out services and functions associated with ACA navigation and outreach. Can you tell us about your state's contracting related experiences? (ask about design - sole-source, competitive contracts? Performance based? How many cycles so far?)
   a. Follow up for contractor/sub-contractors: How has your experience as a contractor/subcontractor been?
6. What is your perspective on the adequacy of state fiscal and human resources for implementation and operation of your state's navigation and outreach services?
7. To what extent has state or local politics play a role in implementation?
8. What do you think your state did and/or does particularly well?
   Probe: Are there "best practices" that could be shared with other states?
   Probe: What resources or support have been important in the implementation of the Affordable Care Act?
   Probe: What are some of the key lessons you have learned from your state's experience?
9. What have been the biggest challenges in implementing the ACA in your state?
   Probe: How were these challenges addressed?
10. Are you aware of any documentation or data collected on your state's ACA navigation and outreach contracts? Sub-contracts?
11. In your opinion, as of today, how would you evaluate the quality of the ACA navigation and outreach infrastructure and implementation in your state?
12. Looking ahead, what challenges do you anticipate?
13. Is there anything else you would like to tell me that may be important for my study? Is there anything we did not ask about that you think is important?
14. Can you suggest other people or groups I should talk to in your state about these topics?