2014

Complexity in National Policy Implementation: A Top-Down Look at the Failure of Healthcare.gov

Samuel Fandrich
Pace University, Dyson College of Arts and Sciences

Complexity in National Policy Implementation:

A Top-Down Look at the Failure of Healthcare.gov

By

Samuel Reese Rolland Fandrich

SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION

DEPARTMENT OF PUBLIC ADMINISTRATION

DYSON COLLEGE OF ARTS AND SCIENCES

PACE UNIVERSITY

APPROVED BY Mary Tinsley, August 2014

Table of Contents:

List of Figures

List of Tables:

Abstract:

The day one failure of the Healthcare.gov website has been deemed a failure in implementation with most of the blame being given to top level officials. This simple conclusion understates the complexity of the process. Research has shown that the implementation of national policy legislation is very difficult and the creation of healthcare.gov was no exception. The inclusion of many actors with the power to create delays hindered the implementation. The inherent complexity in the multilayered implementation structure led to long causal chains that needed to be navigated in order to to establish a working website. The probability of s successful implementation was reduced by the many clearances and decision points that needed to be passed. Some of the blame should be given to the individual administrators but the state-based structure of the Affordable Care Act and the complexity of joint action crippled the website implementation from the beginning.

Intro:

Botched. That is the word most often used to describe the implementation of the Affordable Care Act. It is widely understood that the Obama administration messed up the roll out of its signature piece of legislation. What does that mean? How does a piece of national legislation with all the best intentions end up with the worst reputation? Does it deserve it? Where do we go from here? Proponents of the bill were shocked and ashamed that such an important moment was wasted. Those who opposed the legislation were elated and shouted from the rooftops how horrible the law was and would be. But this was all political rhetoric. The media, pundits, and now almost of the population agree that the whole law was implemented poorly in the beginning. The problem seemed to be short term and to one element of the policy, the national web site. This is the simplification of a very complex problem that took place in a very complex system in an attempt to solve another even more complex problem.

Healthcare reform has been pursued by politicians of both parties for decades, all of them in pursuit of a policy that could break the partisan divide and create some positive change in a system that has begun to spiral toward unsustainable levels. In 2010 President Obama made a breakthrough; although he didn't break the partisan divide, he was able to pass the ACA, sweeping reform of the national health care system based mostly around a conservative idea originally championed by the Heritage Foundation. The idea was that if the goal is to lower the cost of health care premiums for individuals, you need to get as many people into the marketplace as possible. In theory, when more healthy people pay into the system, they will offset all the sick people who draw out. This idea permeates a lot of the ACA reforms including one of its most visible parts, the health care marketplaces.

The ACA sets up, or more correctly, creates the outline for insurance marketplaces where consumers can go and compare healthcare plans simply and directly. The marketplaces also establish a minimum amount of coverage that is offered by the plans to insure quality. The plans in the marketplaces are divided into three levels, with each level providing an increasing amount of coverage but also higher premiums. The coverage levels and premiums are to be established and regulated by the states, but the insurance plans are provided by private health care organizations. The marketplaces also calculate the amount of Federal subsidy that a person can get when signing up for a plan. The Federal subsidy was another major piece of the ACA but not the topic of this research.

The health care exchanges as they are called are a key component of the ACA and, in an interesting concession of federal power, the bill calls for 51 individual exchanges to be set up by the states and the District of Columbia. Each exchange was to house both an individual plan marketplace and a small business marketplace. Should a state not be able to set up its own exchange, the federal government would step in and help. The amount of discretion at the state level has led to considerable amount of variance "as to whether a state decides to establish its own state-based health exchange (SBE), rely on the federally facilitated exchange (FFE), or enter into a federal-state partnership exchange (FSP)" (Noh & Krane, 2014).

Initially, 27 states elected to have the federal government run their exchange, 16 states have taken upon themselves to establish exchanges and 7 states have set up healthcare marketplaces in partnership with the federal government (KFF.com). Of the 27 states with federal exchanges, some oppose the ACA and would rather not have exchanges at all. The 7 states with partnership exchanges don't want to front the cost of the expanded government portion of the healthcare system. Allowing states to create their own versions of the health care

exchange gave them the ability to adjust the markets to fit their state's demands but also formed a complex string of actors whose consent is necessary for successful implementation. The authors of what is considered to be a corner stone of policy implementation literature, Pressman and Wildavsky would be wary of this decision.

Volumes of literature have been written about policy implementation. From the golden age of the field in the 1960's &70's when the top down and bottom up approaches were first outlined, to the study of other national program implementations such as the New Deal or Great Society policies, there exists a vast amount of scholarship to which the implementation of the ACA can be compared. Through analysis it is possible to find out if the national website was an anomaly in what was a carefully planned implementation structure or if the focus of the law was built on a frame of political rhetoric and neglected the nuts and bolts of public administration. Pressman and Wildavsky laid the foundation for this type of implementation study in their book "Implementation," where they concluded that "the study of implementation requires understanding that apparently simple sequences of events depend on complex chains of reciprocal interaction" (Pressman & Wildavsky, 1973). They describe policy as a hypothesis and the implementation as the act of carrying out the framework. The study of implementation starts when the law is passed and continues until the project achieves it goals, or fails. The focus is on the major decisions, actors, and conflicts that arise during this process in order to discover better strategies for creating success in future projects. To Pressman and Wildavsky implementation meant its dictionary definition, "to carry out, accomplish, fulfill, produce, or complete," in the case of their study the object that implementation acted on was public policy. To know what really happened and if avoidable the mistakes that were made during the implementation of the

ACA must be studied in this way, not the superficial rhetoric and slogans that have condemned the administration policy.

The ACA called for state-based exchanges but the reality is that a lot of the states have chosen either to partner with the federal government in some way or have the National Health and Human Services Department (HSS) run the whole thing. This led to a situation that the Obama administration may have not been ready for. At the time of the first open enrollment in September 2013 the national site supported 34 state exchanges. The volume of traffic they created crippled the site when the first open enrollment period began in October 2013, and again near the end in March 2014. Since the goal of the site was to enroll people in health plans, and that for a period the site was unable to do that, it follows that the implementation of the national website was botched. The administration had two years from when the bill passed to when the site launched and on day one it was not ready. There was clearly a defect in the planning and structure of the website; itself the technical nature of the failure is better studied by experts in that field. Did the bureaucratic structure lead to any of the day one problems of the website? As Pressman and Wildavsky point out, delays in national policy implementation often stem from the complex nature of the bureaucracy itself. These types of delays during the development of the national website could have led to the day one failures and the inability to fix the problem.

The purpose of this research is to focus narrowly on the implementation of Healthcare.gov. Starting with the final decision to let the contract wan working backward to see if goals the goals changed though the process Then using the outline of Pressman and Wildavsky study organize a grouping of decision points and clearances that made up the government structure implementing the policy. The hope is to find out if there were structural limitations to the healthcare website and if these limitations led to the failure of the website.

Review of Literature:

The Pressman and Wildavsky study was a watershed moment for the study of implementation in Public Administration. It is the foundation for the research on this topic. Their definition of implementation as "the ability to forge subsequent links in the causal chain so as to obtain the desired results" moved the discussion of implementation beyond the passing of legislation to real world events (xxii). They noted that implementation consisted of "complex chains of reciprocal interaction" (XXV) between both governmental and non-governmental actors. In what may be the longest subtitle ever for a public administration book, they laid out their view of the implementation process; "Implementation: How Great Expectations in Washington Are Dashed in Oakland; Or, Why It's Amazing that the Federal Programs Work At All, This Being a Saga of the Economic Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation of Ruined Hopes."

Pressman and Wildavsky studied a program by the U.S. Economic Development Association (EDA) that intended to create jobs for the hardcore unemployed people of Oakland, California. The project proposed to give $23 million in economic grants and loans to businesses in Oakland with the stipulation that they use the money to create jobs for the local residents. As the subtitle of the book suggests, the program was not the triumph that the EDA had hoped. When the program was initially proposed all the actors involved supported the plan, those who were to receive the grants and loans were sympathetic to employment restrictions, the EDA was intent on delivering a successful program in Oakland, and the local authorities supported the concept of development and local employment. After the initial agreement, one of the major actors in the EDA's Oakland Project wrote a book, *Oakland's Not For Burning,* praising the

success of the project. Yet as Pressman and Wildavsky would point out, five years after the initial agreement almost none of the work had been completed and very few jobs had been created.

How could things end so poorly in a program that had so much initial support? The complexity inherent in implementation turned minor decisions into major delays and in some cases, stopped work entirely. Through their research Pressman and Wildavsky were able to conclude that implementation consists of a chain of interdependent events that lead from the desired outcome initially proposed to the eventual real outcome of the program, and that "the longer the chains of causality, the more numerous the reciprocal relationships among the links and the more complex implementation becomes" (XXIV).

The Oakland study focused on the system of implementation noting many stumbling points along the way. How many people had to act in order to push the policy forward and how many times did they have to act were key factors in the speed of policy implementation. Pressman and Wildavsky called these moments' clearances, "each instance when a separate participant is required to give his consent" (xxv). There are times in the implementation process when many actors have to give clearance at the same time that could possibly lead to policy change, or delay. Pressman and Wildavsky call these Decision points, "each time an act of agreement has to be registered for a program to continue. These are the basic building blocks for a top down study of policy implementation. Pressman and Wildavsky concluded that the longer the chain of interdependent parts involved in implementation, the more possibility there was for delay. By cataloging the number of decision points and clearances, it is possible to get a picture of the causal chain that directed the implementation; or, in the case of the Oakland Project, delayed and ultimately crippled the project.

In the Oakland project there were 30 major decision points (a decision when a major participant had a discernible opportunity to make choices), many with multiple actors involved. The total number of clearances needed to get the EDA from the initial decision to get involved in Oakland to the letting of contracts was 70. Pressman and Wildavsky concede that their analysis was oversimplified and reliant on the assumption that all the decision points and clearances were made independent of each other (102). The total number of clearances seems low for a national policy intended for a local municipality involving contracts let to privet groups. Understanding a clearance as a necessary approval for the program to move forward, then the program must get 70 approvals in order to have a chance to succeed. In the Oakland study, the assumption was made that each decision maker had no less than an 80% chance of giving the necessary clearance, which is optimistic. The probability of getting all 70 clearances, even at 80% positive responses, was found to be .000000125. Even if you start with the likelihood of 99% positive response from every actor who needs to give clearance, the probability only reaches .489 (107). This purely mathematical form does not take into account many factors that were later explored in-depth in the field of implementation but it does shed light on the pessimistic tone of the book's subtitle.

Another important realization in the Pressman and Wildavsky study was how the attitude of each actor affected the outcome of the program. From the top down view of implementation there are many actors that have the ability to affect a program. Each actor that needs to give clearance had the ability to delay or expedite the program based on his or her own perception of the program. "Those who manifest high intensity will use up resources to control outcomes," (117) in either a positive or negative way. Actors with a positive view of the program and high intensity toward it could produce delays by refusing to compromise their vision of the program,

while actors with a negative view and high intensity would use their resources to change fundamental parts of the program. Low intensity actors with a negative view of the program can also produce delays but over peripheral program factors (117).

This realization makes it easy to understand Pressman and Wildavsky's pessimism; their study showed them that almost all actors in the implementation process were capable of producing delays. They were the first to highlight the "implementation deficit" that characterized the gap between initial goals of an agreed upon policy and the final outcomes. Though this study was one of the first, and one of the most well-known, studies of implementation, it was by no means the last. Pressman and Wildavsky started what was to be known as the "top down" study of implementation which focus on the hierarchical bureaucratic structure of the implementation process. The study of implementation soon expanded to include the "bottom up" studies that focus more on the public administrator's ability to affect outcomes.

In what appears to be a rebuttal to Pressman and Wildavsky, Bowen(date) agrees with some of the fundamental principles established in the landmark study, but suggests that there are ways to increase the probability of success in a program other than reducing decision points and clearances. Bowen suggests that effective public administrators have tools to address issues of implementation such as, "packaging of clearances, engineering bandwagons and policy reduction" (Hupe, 2010) (Bowen, 1982). "Packaging implies that one negotiation entails a number of clearances needed for several program elements. Bandwagons refer to the situation in which each clearance obtained increases the probability of the next one. An agreement as a result of one negotiation enhances other clearances. Policy reduction entails the differentiation of a policy program into several parts to be treated separately" (Hupe, 2010). Because of these factors, Bowen justified an "increased optimism about the likelihood of successful

implementation" (Bowen, 1982). Any current study of policy implementation would not be complete without addressing the street level administrator's ability to affect a program in the context of the implementation structure and implementation regime.

Implementation happens in a complex environment that consists of both the "top down" hierarchy and the "bottom up" effects of the local administrators. Each actor is making decisions based on their own goals. When national policy is negatively affected by local administrators, it is suggested "either that there has been a failure of control, or that there have been interventions in the policy process that are seen as illegitimate" (Hill & Hupe, 2003) when this could not be the case. It may be that the street level bureaucrat had to adjust the policy in order to make it work in the local reality. This is commonly referred to as 'Multi-layer governance' and it describes the reality of the structure of government and the possibility that implementation be seen as an adaptive process. Although changes like these are often "presented as either involving disobedience on the part of implementer or poor judgment about reality on the part of policy originators" (Hill & Hupe, 2003), allowing for change in the implementation process does not constitute failure but does have an effect on the perception of the policy.

It has been observed that 'centralization enhances congruent implementation" (Hupe, 2010), in the sense that the policy happens the way that it is supposed to and that 'statutory coherence' has a positive effect on national policy implementation in a multi-layer environment (Mazmanian & Sabatier, 1983). As Pressman and Wildavsky first suggested, a national policy must be coherent and delivered centrally through as few layers of government as possible. Even then, it will experience delays and the skills of the lower level implementers will be tested, as they attempt to stick to the intent of the statute while bargaining for clearances along the way. As implementation travels down Pressman and Wildavsky's causal chains, it begins to enter a more

horizontal atmosphere where it is influenced by actors outside of the government hierarchy, such as the business owners in the Oakland study, whose actions are not governed by the policy and whose interests may run counter to it. There are parallel causal chains that interact with each other, which Hupe refers to as the 'thickness of government' not just top down or horizontal but both (Hupe, 2010).

Given this context, it seems the ACA was/is destined for the botched implementation that the media has described though an astute observer of implementation policy knows the battle is just beginning. Like the Social Security Act in 1935 and the Great Society policies of the 1960's before it, the ACA has been hailed as a great legislative achievement but success now lies in its ability to prove its theory correct and establish the system it prescribes in working order. A main feature of that theory is the creation of the Health Care Exchanges and their ability to reduce the uninsured population.

Susan M Barrett, another leader in the field of implementation research, narrowed the four key factors of perceived "implementation failure" as described by the thinkers of the 1970s, these factors include

1. Lack of clear policy objectives; leaving room for differential interpretation and discretion in action;
2. Multiplicity of actors and agencies involved in implementation; problems of communication and co-ordination between the 'links in the chain';
3. Inter- and intra- organization value and interest in differences between actors and agencies; problems of differing perspectives and priorities affecting policy interpretations and motivation for implementation;

4. Relative autonomies among implementing agencies; limits of administrative control (Barrett, 2004).

A lot has changed since the 1970s and the field of public administration has evolved new strategies and now involves more actors both public and private. In 1981, researchers Hjern and Porter declared the "single lonely organization" dead in the study of implementation. A new reality of New Public Management (NPM) and the idea of governance brought in more actors who in turn create more decision points and clearances, not to mention motivations. Implementation that takes place completely within one government institution may benefit from public sector employees that, theoretically, "all share some common commitment to public sector values" (Peters, 2014). NPM has introduced market forces into the implementation process, focusing on a "principal- agent relationship between public sector and those market actors actually delivering the services" (Peters, 2014). Modern implementation structures must also adapt the complex reality of network governance in the public sector where there still is a focus on principal-agent relationships but the involvement of multiple non-governmental actors adds complexity.

Looking at the implementation of the Affordable Care Act with the foundation of knowledge that implementation literature can give, may make it possible to give an educated opinion on whether or not the implementation was botched. The idea that any national policy will struggle during the implementation process is well founded but did the administration plan for the inevitable problems that led to the obvious delays. The clear culprit of the failed rollout was the national health care website so it is the most obvious place to look at the implementation structure of the ACA. What were the structural limitations to the implementation of Healthcare.gov? Did these limitations lead to delays that affected the outcome of the ACA?

Pressman and Wildavsky focused on the causal chains of implementation noting that their length and complexity have a major effect on the probability of implementation. However, much of the more recent study of implementation focuses on the ability of lower level public administrators to affect the success of a policy. The early implementation studies focused on four main factors of failure.

Methodology:

This will be a pure research study on the implementation of one small piece of the affordable care act. Discovering the limitations of the implementation structure of the Healthcare.gov website my ultimately lead to larger conclusions about the implementation of the entire law, and implementation practice as a discipline.

The goal of this research is to study the implementation framework that lead to the problems in healthcare.gov roll out, and if it was the implementation framework that contributed to the failure at the initial launch. This will be a case study on implementation that focuses on the system that chose how the website would be created and who would create it.

The design of this study will be based around the Pressman and Wildavsky study. The eventual hope will be to establish major decision points and clearances that had the ability to affect the roll out of the healthcare.gov website. This case study will focus very narrowly on the decision to choose the contractor that created the website. From the day one failure the research will progress backward up the causal chains using Richard Elmore's model of Backward Mapping. Asking at each level of the implementation structure what is the ability of this unit to affect the behavior that is the target of the policy? And what resources does this unit require in order to have that effect?

Once the different levels of the implementation structure and their ability to effect the policy have been identified there will be a summary of the findings similar to the top down approach of Pressman and Wildavsky. Starting from the initial policy goals and identifying the decision points that had the ability to hinder the implementation of the law.

This research hopes to answer two questions; what were the structural limitations to the implementation of the healthcare.gov website? And, did these limitations cause delays that affected the outcome? The structural limitations are things that hindered the implementation of the affordable care act. For Pressman and Wildavsky this was the length of the causal chains in the implementation framework, or the number of decision points and clearances it took to get to the eventual outcome. The variable in this research will be the decision points and clearances. Only the major decision points as classified by Pressman and Wildavsky will be considered. In order to get this information there will be an extensive document review starting with the final contract letting and working backwards to the formation of policy.

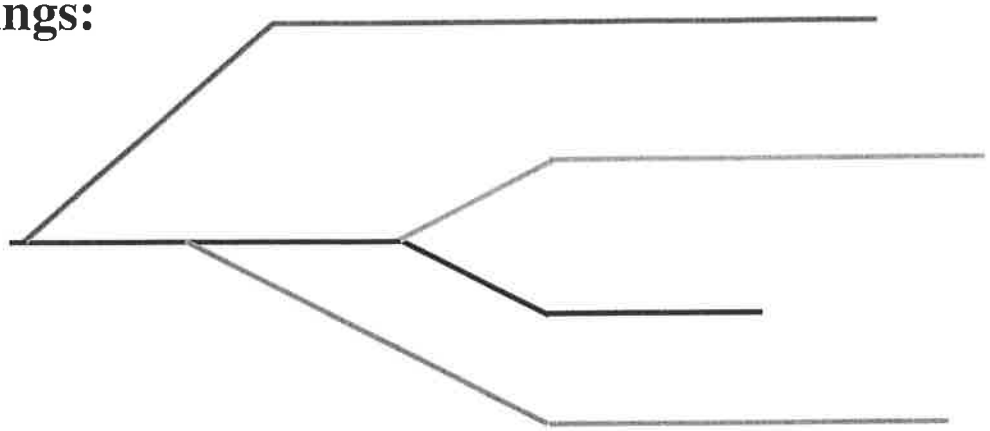
This research will provide a narrative describing the major decision points and clearances along the causal chains that lead to the Healthcare.gov site. Compiling the data in a table that displays the major decision points and the actors involved will create a visual representation of the implementation structure. Once this is created it will be possible to use Pressman and Wildavskys formula to find the probability of implementation success.

The second research question is: did the limitations to implementation lead to delays that had an effect on the implementation of the Affordable Care Act? This research will compare the proposed timeline for implementation to the actual timeline to see if early delays caused concessions in the implementation process. Through review of public documents and media articles this research will hope to compile three timelines; one that shows the original timeline for implementation, one that shows the actual timeline, and the last will show the major decision points in the implementation process. The variable will be how many of the decision points were related to delays in the implementation. The data will not be an able to show causality, but for

analytical purposes may show a correlation between the implementation structure and delayed benchmarks in the implementation process.

This study will have several major limitations. Due to the charged political arena in which the Affordable Care Act was implemented much of the coverage and documents will be bias. Although the political bias that may cause the greatest threat to the research will be that of the researcher. It will be very important to not take a political stand or paint the implementation in one political view. This research will most likely have no external validity due to the very narrow nature of the research. It may however, have internal validity as a biases of explanation for the problems of implementation in the affordable care act and more specifically the Healthcare.gov website. Although the narrow scope will allow for very specific results this research will be limited in its explanatory ability. The goal is to understand the problems with the healthcare.gov roll out, but this research will only outline the structural defects in relation to the known problems. It will be a foundation for study, that will explain the structure and to the cause of the implementation problems related to the ACA.

Findings:



In order to find out if the healthcare.gov rollout was botched, the first step was to find out what happened. There is a lot of material and partial reports on the timeline of events that led up to the website failure on October 1st, but the most complete information found in this research came from two reports by the Government Accountability Office (GAO). The first report issued in June 2013 titled "Patient Protection and Affordable Care Act, Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges," was issued prior to the website launch and warned of missed deadlines and possible issues. The second GAO report was issued to Congress in July of 2014; its title, "Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management," suggests that the website rollout was indeed botched. Both of these sources were crucial to the research as they presented imperial data on dates and delays during the implementation process.

Data for this research was also taken from news articles, congressional testimony and official rules issued by HHS, CMS, and other government agencies. Full citations of these articles can be found at the end of this paper.

The basis of this research starts where the implementation ended--the website failure on October 1, 2013. From all technical accounts, the Federally Facilitated Marketplace (FFM) set up by the contractor CGI federal Inc. was unable to meet the demand of traffic. This caused the

website to shut down. The website was created for the federal government by more than 50 different contractors and consultants, the two largest were CGI Federal and QSSI.

CGI federal was responsible for the FFM website itself, providing the functionality to be able to register an account, apply for coverage and see the results. QSSI was contracted to build the Data Hub, which securely connected the FFM with other State and Federal agencies in order to verify personal information, program eligibility, and possible subsidies and the Enterprise Identity Management Software, a virtual database that stored applicant's information. Figure 1.1 shows a simple diagram of the structure of the website. It may seem to be a simple system but as one CGI executive put it in his testimony to Congress, they were tasked with building a system in two years that would normally take five years to build. The short time frame and complex nature of the technical structure was not the only problem facing the implementation of Healthcare.gov. Figure 1.1 below illustrates the architecture of the website.

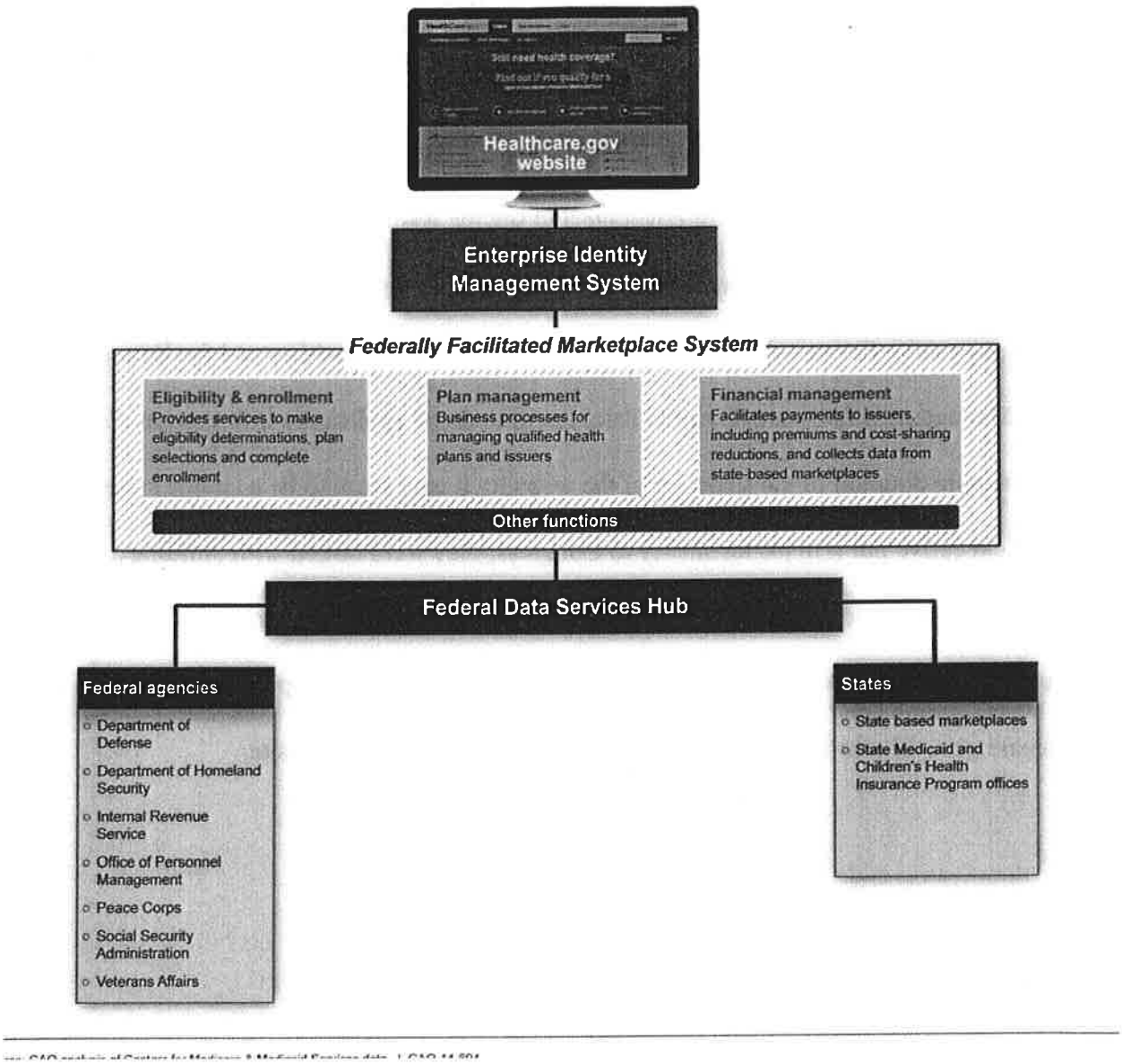


Figure 1. Architecture of the website. Source: United States Government Accountability Office

The ACA set up the legal basis for 51 State Based Health care exchanges that would need access to nine Federal agencies and numerous private corporations on October 1.st Healthcare.gov was the technology platform for 36 of these exchanges. The causal chains in the implementation of the web site were very long and complex. In order to frame these chains into logical order the research has shown that there were four main groups of actors: the Contractors

(CGI and QSSI), the Federal Agencies, the States, and the Policy Group (which includes HHS and CMS). These four, all very necessary to the success of the FFM, had varying levels of control over the implementation process. Each group had its own decision points and clearances that needed to be reached before the website could be fully functional. The next section will outline each group's main actors, their view of the policy, their intensity to the policy, and the ability to affect the outcome with their decisions.

The CGI and QSSI were tasked with creating the largest components of the website. The functionality of the whole system was based on the two products they were commissioned to build the FFM website and the Data Hub. As an outside contractor, however, they were not driven by the success of the policy itself (the ACA). The contractors were driven by their companies' corporate and financial success so they had a high intensity toward creating a successful website but probably little interest in the healthcare law itself. CGI and QSSI were in the dificult position of having great influence over the success or failure of the website, but very little influence over the policy that dictated it. As the CGI and QSSI executives would later testify before congress, the constant uncertainty in design and function of the website led to delays and failure of the implementation.

Another group of actors who had very little ability to affect the policy but had pivotal roles in the final outcome of the website were the other Federal agencies who needed to give access to their secure records in order to establish the eligibility of users. This included: The Department of Defense (DOD), The Department of Homeland Security (DOH), The Internal Revenue Service (IRS), The Office of Personnel Management (OPM), The Pease Corps, The Social Security Administration (SSA) and the Office of Veterans Affairs (VA). These groups are all part of the Federal government and most likely had an overall positive attitude towards the

ACA but it would seem that their main objective was the security of their own data archives. These groups did not have the ability to affect the policy decisions but they did have the ability to delay certain benchmarks in the process by not giving clearances. In order for the website to access the secure data from these agencies each group needed to provide up to three clearances: a Business Service Definition (BSD) which described the agencies' role in Healthcare.gov; a Computer Matching Agreement and/or a Data Use Agreement that gave permission to the Data Hub to access and use their data. This large number of clearencess in the technical development of the website adds links to the causal chains of the implementation.

The states also had to give a lot of clearances before the website could be finalized. For the purpose of this discussion the states will refer to all 51 potential State Based Exchanges (SBE) including the District of Columbia. Each state was given the power by the ACA to establish its own SBE, they as a group had very high ability to affect the outcome of the policy. In the end only a small fraction of the states chose to run a SBE, the rest chose a FFE. Several different models of FFEs were established through extensive negotiations with the Federal Government, all of which used the national Healthcare.gov website with states having varying degrees of management over health plans and insurance companies. The states also had vastly differing views of the overall policy that ranged from outward acceptance to legal opposition. Each state represented a link in the causal chain of implementation of the website because establishing the nature of their involvement and agreeing to the terms represented a possible delay.

The final and most influential group studied here is the policy group. This group is made up of the federal government agencies directly charged with creating the Healthcare.gov website, the Department of Health and Human Services (HHS) and later the Center for Medicare and

Medicaid Services (CMS). This group had a very positive view of the program and a very high interest toward getting the goals accomplished, based upon their direct connection to the President. They also have the greatest ability to control the outcome of the policy. They directed the implementation, chose the contractors, negotiated with the states, wrote the agreements with the other federal agencies and were the ones who set the rules for the exchanges.

It seems easy to blame the Policy Group for the failure of the Healthcare.gov website because the end result was their responsibility, and the final GAO report does basically that. However, the complexity in the implementation framework that created the website shows how difficult a task this actually was. Small delays in the timeline possibly led to unforeseen problems in other portions of the implementation.

Timeline:

The narrative timeline will move through each group of actors stating major decision points and delays that were found along the way.

Policy Actors:

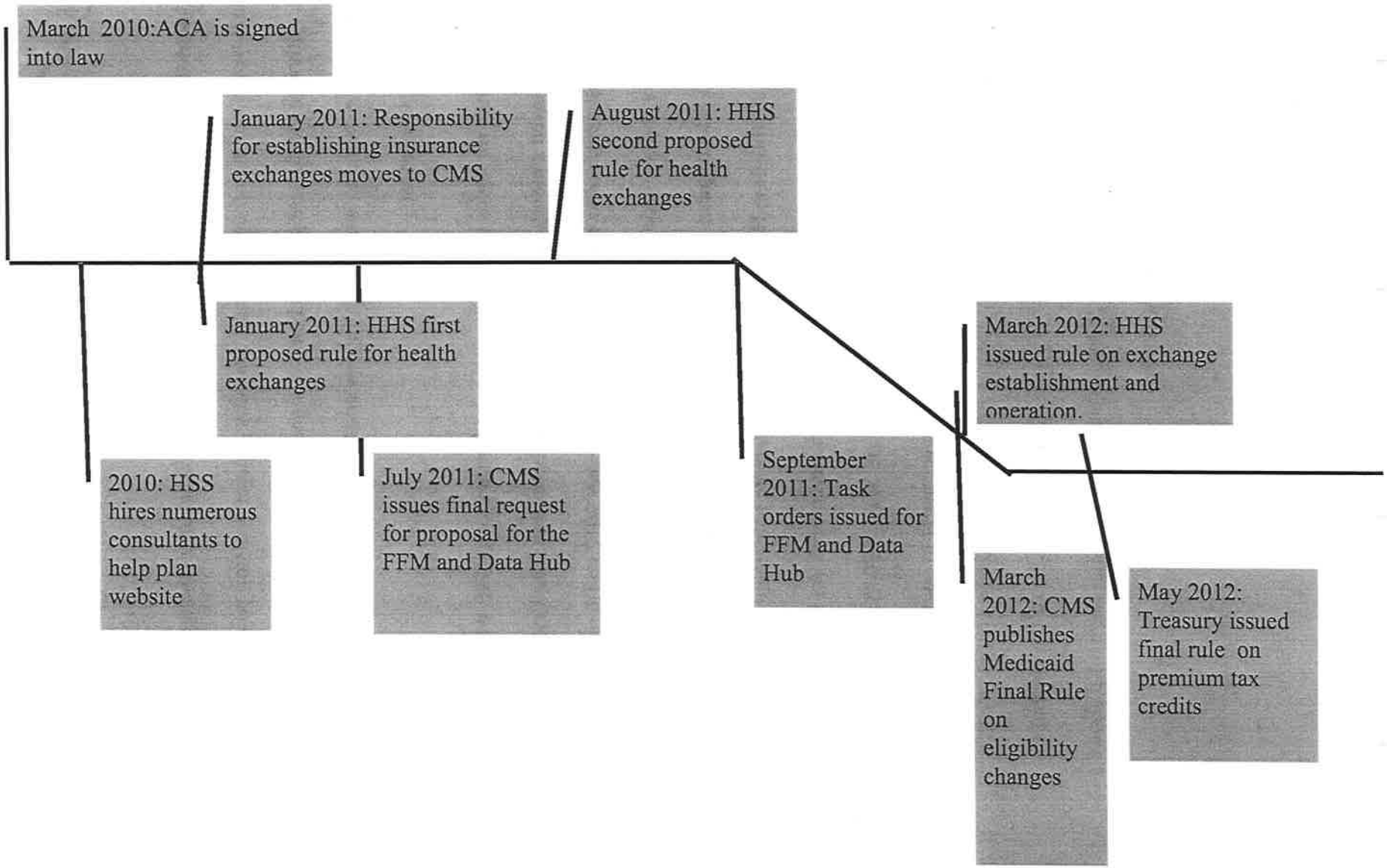
In March of 2010 the Patient Protection and Affordable Care Act was first signed into law starting the implementation and policy potion of Healthcare.gov. Most of the responsibility to implement the ACA fell to the HHS, this included establishing the SBE called for in the law. HHS spent most of the first year hiring technology consultants and planning what the technical structure would look like. The first GAO report showed large contracts for technology firms such as Booz Allan Hamilton, The Mitre Corporation, QSSI and others going back to 2010. In January

of 2011, the group in charge of establishing the Healthcare.gov and the exchanges was moved from its position in HHS, where it reported directly to Director Catharine Stabiles, to CMS. In January 2011 HHS published the first proposed rule governing theHealthcare.gov exchanges. Under the national administrative law it is required that any rule changes be first published in the national register and open for a period of time for public comment. This is the first of several such rules from HHS that were necessary for the establishment of the exchanges. It is worth noting here that the open comment period for this first rule brought in 24,781 public comments. Establishing this rule was a major decision point for the implementation of the website because when finalized, it identified the basic functions of the website, the other agencies that would be involved in the approval process, and it established the initial rules for the FFEs. The next major policy decision was the release of the Request for Proposal for the Data Hub and the FFM in July of 2011. This began the federal procurement process required to select the contractors.

The final task orders that outlined the official scope of work for the FFM and the Data Hub were not issued until September of 2011. According to the contractors CMSs requirements were continuously changing and this caused problems in the development of the website. Although these statements come from the contractor that failed to have the website ready, there may be some evidence of this in the fact that HHSs Final Rule for the health exchanges wasn't published until March of 2012. That is six months after the task orders were issued to the contractors to begin creating the website. This final rule also included portions that served as interim final rules that delayed the final judgment of some key issues about the health exchanges to later rules, this included the rules on tax credits and eligibility. The rules that govern the FFM and the healthcare exchanges are still being modified. The figure 1.2 below shows the timeline the policy actions during the implementation of the affordable care act.

Government , Legislative and Regulatory Decisions Timeline

Figure 2



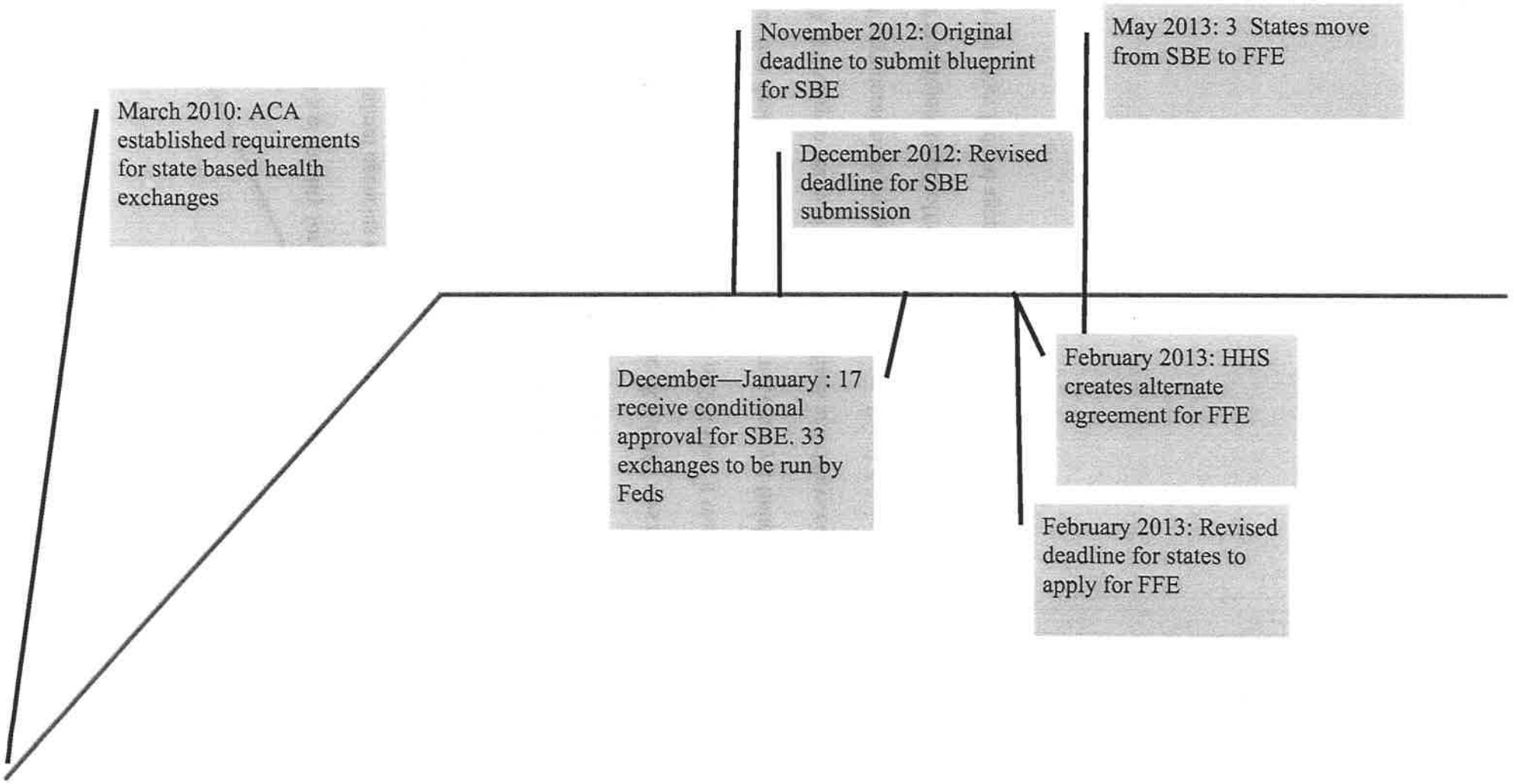
States:

The law states that should a state choose not to establish a health exchange that the federal government would set one up on its behalf. This was a major decision point for the individual states. Although Healthcare.gov was being designed to incorporate FFE and state access to the Data Hub, the extent to which each state would participate was not established until very late in the website development.

The original deadline for states to submit a blueprint for their own SBE was November 2012 but this date was delayed a month in order to give states more time. The first seventeen states received conditional approval to run SBE between December 2012 and January 2013. This meant that Healthcare.gov and the Federal government would be responsible for the technology portion of at least 33 FFE. The original deadline for states to apply for a FFE was moved over a month to February 2013. At this time HHS also created an alternate agreement with several states that changed the amount of state participation necessary for an FFE. As late as six months from the initial rollout, states were shifting their participation; in May of 2013 three states that had been conditionally approved for SBE asked the federal government to take over the technology portion of their exchange. Thus they became FFE and added to the Healthcare.gov capacity. The states' cooperation with the ACA was important to the success of the law but the cooperation of the federal agencies was pivotal to the success of the website. Figure 1.3 shows a timeline of the state participation in the implementation.

Development of the State Exchanges

Figure 3

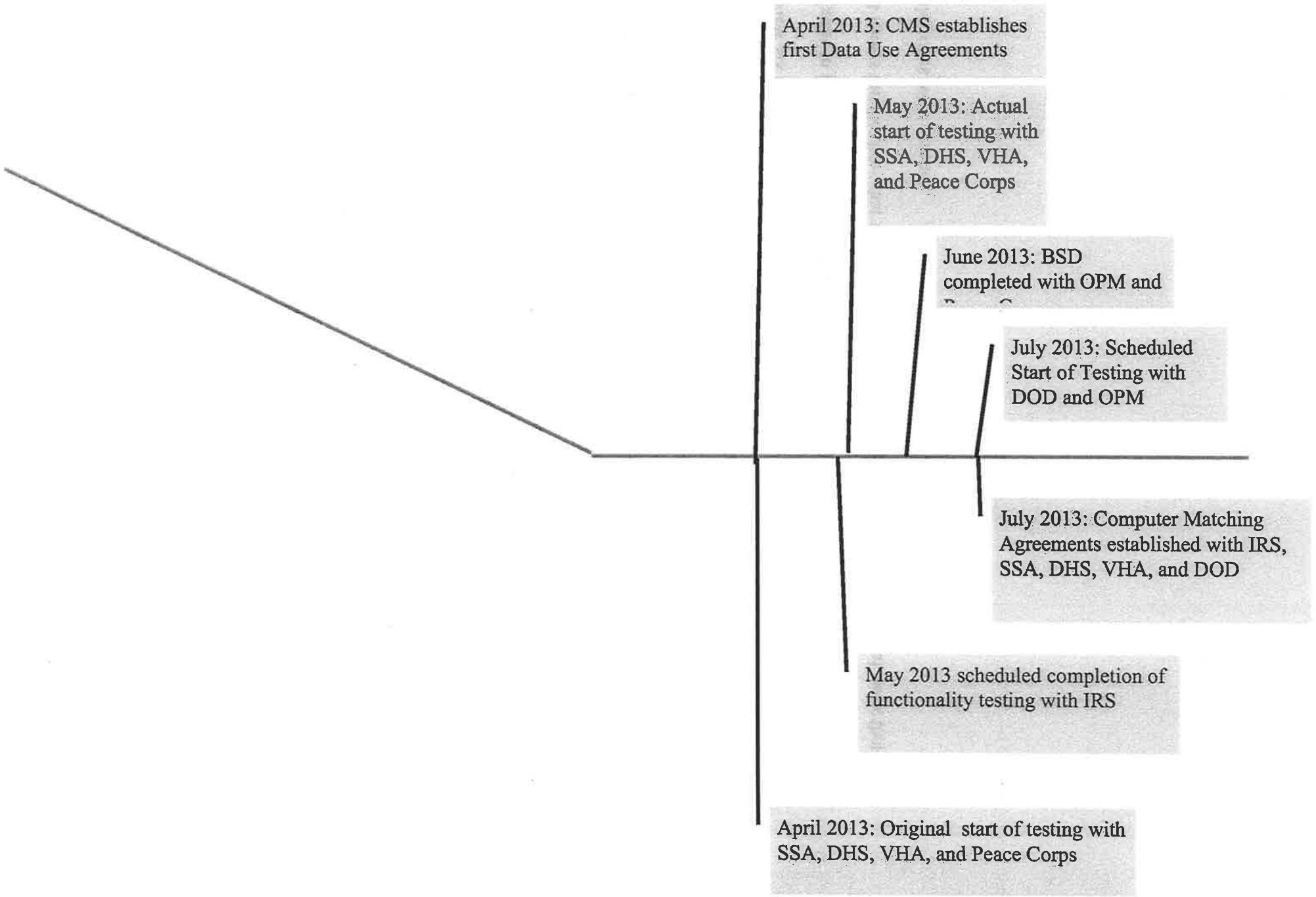


Federal Agencies:

In order to verify a person's eligibility for a health plan, Healthcare.gov needed to check their information through seven federal agencies and HHS. In order for these interactions to happen, the agencies had to come to agreement on the terms of this relationship. It wasn't until April 2013 that CMS established the first round of these agreements with SSA, DHS, VA, and the Peace Corps. CMS's original plan was to start testing the data hub's access to this information in April but didn't actually start testing until May. Also in May of 2013, CMS missed its own deadline to finish functionality testing with the IRS. CMS was scheduled to start testing the data hub with the DOD and other agencies in July of 2013 but it was reported by the GAO that CMS had missed that deadline and at the time had not even yet finished all the agreements with the DOD. It is easy to see how missed deadlines and delays caused by the high level of complexity could have derailed the implementation here. Small delays had a ripple effect and caused this portion of the project to get off track. The next figure shows the implementation of healthcare.gov through the other federal agencies.

Data Hub Integration with other Agencies

Figure 4

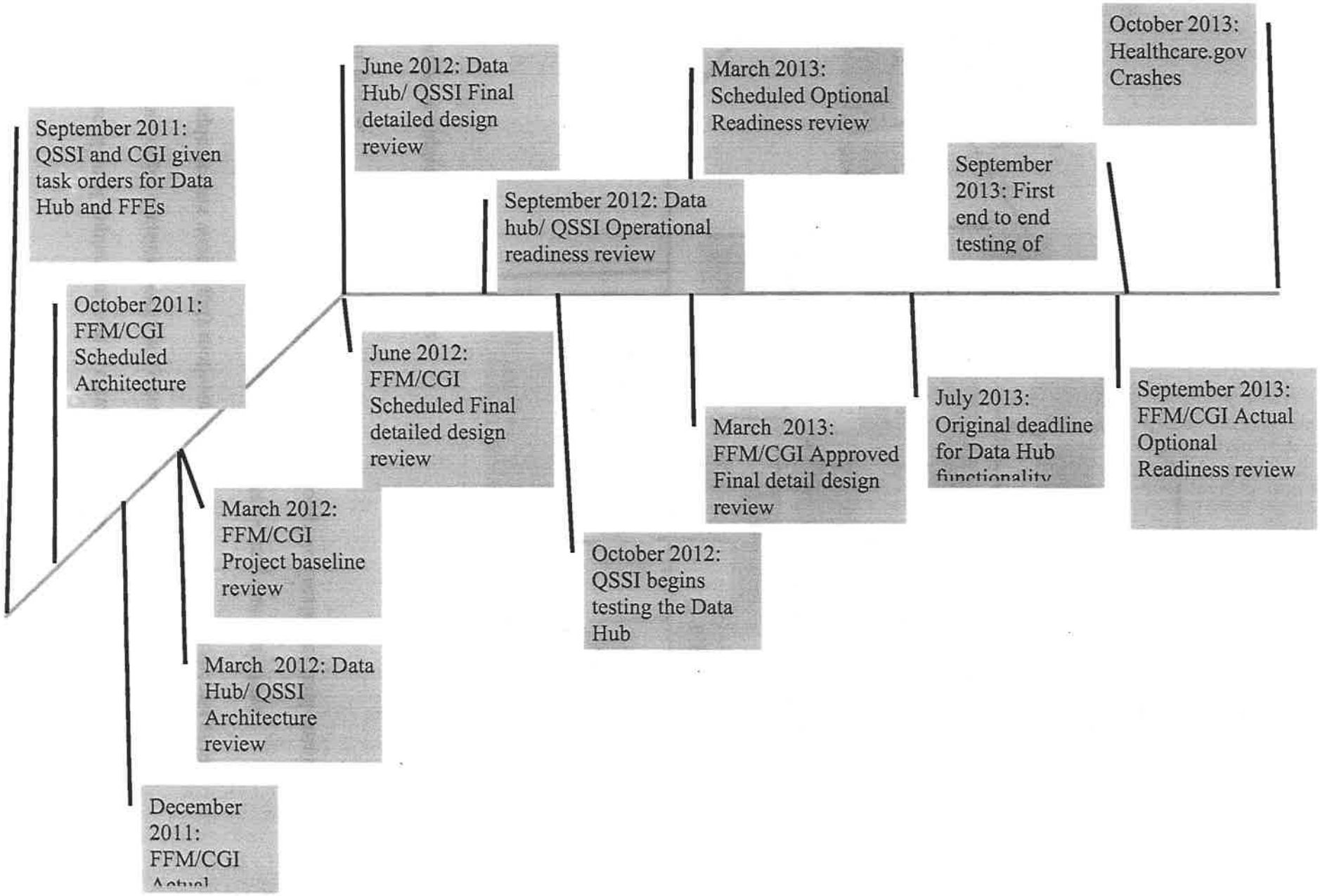


The Contractors:

The most visibly derailed portion of the project was the contracted technical development of the website. As the timeline has shown so far, this was just one piece of the causal chain that made up the implementation of Healthcare.gov. The final task orders to create the FFM and Data Hub were issued in September of 2011. CGI Federal and QSSI worked with CMS to set up very specific benchmarks. The original plan called for each project to have four milestone reviews during the implementation to track the progress of the task orders. The Architecture review, The Project Baseline review, the Final detailed design review and the Operational readiness review. The Data Hub was able to pass its reviews on the scheduled dates and was ready to begin implementation in September of 2012. The FFM however was plagued by delays in the review process. The first review was delayed two months, the third review nine months, and the final review six months. Due to these delays the allotted time for implementation fell from seven months to just one, the time for development and testing fell from nine months to just six. Figure 1.4 shows the the dates that were originally set for the benchmarks and the actual dates that the milestones were reached.

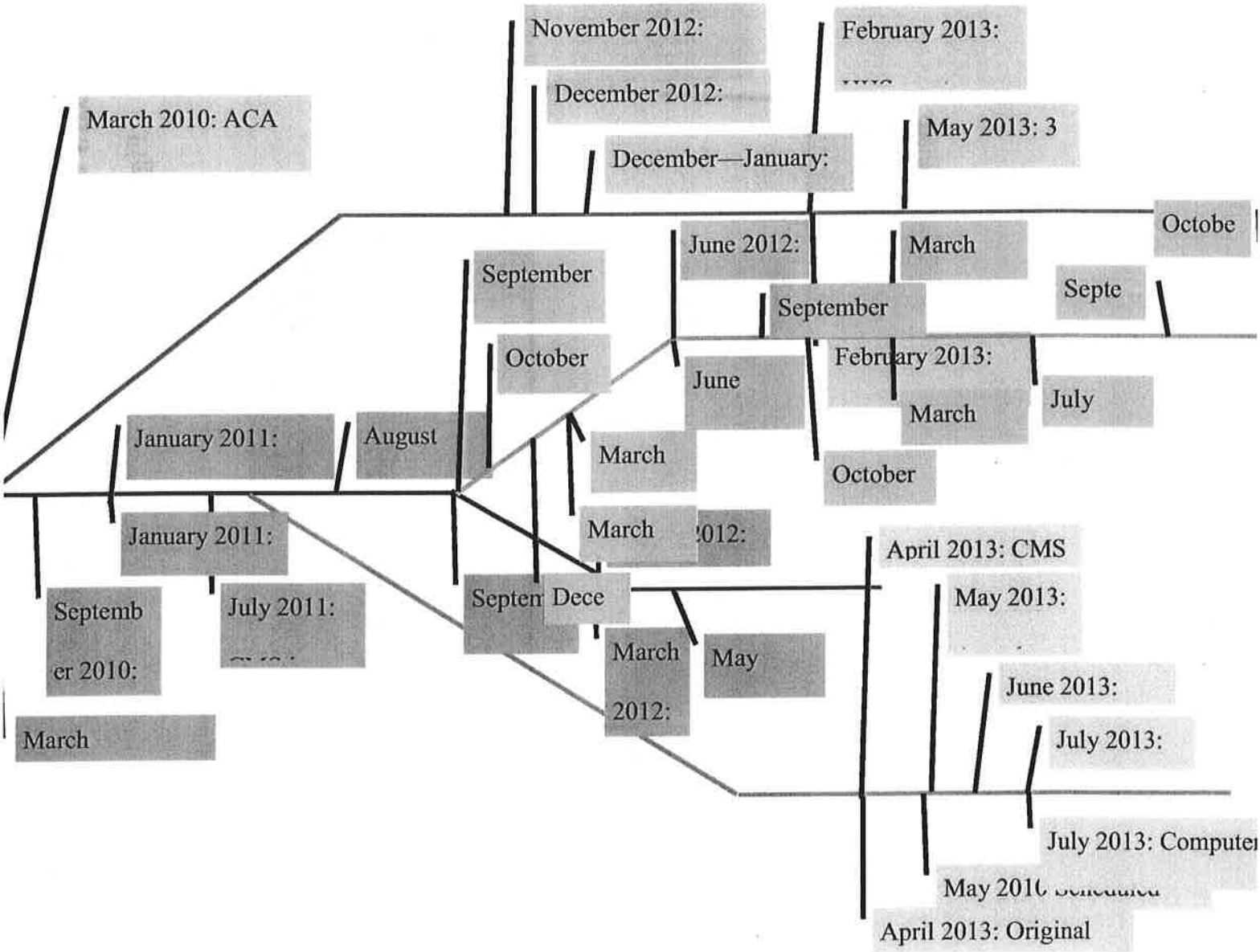
CGI & QSSI Contractors and Technical Development

Figure 5



When the timeline of implementation is connected, the complexity is apparent. This simple outline shows major decision points and clearances needed for the program to progress. Even though the implementers were highly motivated and passionate about the success of this project, the complexity and the inherent delays it caused created a drag that could have ultimately led to the failure of the website. Figure 1.6 is the complete timeline of implementation for these four groups.

Figure 6 Complete Implementation Timeline



Analysis:

The analysis of this research will be based mostly on the work of Pressman and Wildavsky. The goal is to identify the structure of the causal chains of implementation. Then, to identify whether the complexity in the structure of implementation led to delays that jeopardized the final outcome on October 1, 2013. This will set a scientific basis for the claim that the implementation of the website was botched. In their analysis of the Oakland project, Pressman and Wildavsky showed the complexity of joint action and its impact on the implementation process. They focused their research on the number and attitude of the actors, the number of major decision points and the total number of clearances. They pointed out that each one of these pieces had the potential to cause delays and that delays had a major effect on outcomes.

The actors and groups of actors listed in the research do not represent every actor that participated in the implementation of Healthcare.gov. The actors here were chosen because they represent the structural components responsible for the parts of the implementation as mandated by statute or contract. Pressman and Wildavsky were able to narrow their focus down to individual people who had the ability to give clearance and negotiate decision points. At this point in the research on the ACA, the perspectives of the individual people who implemented the law are unclear. To create a top down view of the implementation of Health care.gov, this research focused on the organizations and groups who participated in the implementation and assumed their attitudes and intensity to the law based upon their role in the implementation. The table below shows the groups and actors that played a role in the implementation and describes their role and assumed perspectives.

Table 1 **Evaluation of the Actors Involved in the Implantation**

Group	Actors	Connection with the Program	Perspective	Sense of Urgency
Policy Group	HHS	Given the responsibility under the ACA to implement all the functions of the law	Very positive - the main goal was to have a successful website capable of giving all Americans access to the FFMs	High
	CMS	Given the responsibility by HHS to create the Healthcare.gov website	Positive attitude the main goal was to create a working website that gave access to the FFM by the deadline of October 1st 2013	High
	Executive	Created the ACA and the policy that drove the implementation	Considered the signature piece of the president's term in office the executive branch of government viewed the policy very favorably	High
States	50 States &D.C.	The ACA put the responsibility on the states to create their own exchanges that were suited to the needs of their residents	Split - the perspectives differed greatly between states as did the major goals.	Moderate
	Elected Officials of the 50 States	elected Officials had to approve funding for the ACA and defend their positions on the polarizing law	The law had a polarizing effect on politicians, some for some against its implementation	Low
	Administrative Personnel	In charge of the technical issues like registering health plans and state specific information	Mostly positive - unlike politicians many healthcare administrators were hopeful that the ACA and the FFM would work out for their constituents - Major goal was to give better quality healthcare to the people of their state	Low
Federal Agencies	DOHS IRS OPM Peace Corps SSA VA	All of the other federal agencies played similar rolls in the implementation of Healthcare.gov. They facilitated the approval process by giving access to their records.	The perspective of the other federal agencies is unclear, although they needed to cooperate with the implementation of a legally mandated system, that being healthcare.gov.	Low
Consultants and Contractors	QSSI	They were responsible for the creation of the Data Hub and the Enterprise Identity management Software	Their view of the policy was neutral although they had a very positive position on completing the task orders given to them in a timely manor	High
	CGI	They designed the Healthcare.gov website and the technical system for the FFM	Their view of the policy was neutral although they had a very positive position on completion	High

Based upon their view of the ACA implementation and their sense of urgency in the completion of the website, all of these actors have an ability to create delays at decision points. The table below shows the major decision points that were mandated by statute or contract during the implementation of the Affordable Care Act. This sample does not represent every decision point in the process but major points that had the ability to halt or delay the rest of the implementation. Taken from the previous timeline, this table shows the main actors in each group and the decision points that were required for the website to pass through each group.

Table 2 **Decision Points**

Group	Actors	Decision Points
Policy Group	HHS	Website Design
	CMS	Giving implementation responsibility to CMS
	Executive	Selecting the contractor
		Finalizing the rules that governed the marketplaces
States	50 States &D.C.	Whether or not they would participate at all in the Market Places
	Elected Officials of the 50 States	Would they run a SBE or an FFE
	Administrative Personnel	Later what type of FFE/ how much control did they want over the FFE
Federal Agencies	DOHS, IRS, OPM, Peace Corps, SSA, VA	What would they share?
		Was the system safe to access their information?
Consultants	QSSI	Architecture review
	CGI	Project Baseline review
	53 others	Final detailed design Review

Pressman and Wildavsky take their research even farther by connecting all the actors who need to give clearance to every decision point and establishing a total number of agreements needed to pass every decision point, and ultimately the total needed to complete the implementation process.

Table 3

Necessary Clearances

Decision Point	Parties Involved	Total Agreements
Website Design	HSS, CMS, Consultants	3
Giving Responsibility For Implementation To CMS	HSS, CMS	2
Selection of the Contractor	HSS, CMS	2
Architecture review	CMS, QSSI, CGI	3
Project Baseline review	CMS, QSSI, CGI	3
States Choice to Participate in the Market Place System	50 States	51
Finalizing the Rules that Governed the Market Places	HSS, SSA, Treasury	3
Final detailed design Review	CMS, QSSI, CGI	3
States Choose to Run a SBE or FFM	50 States (Elected leadership and administrative personnel), CMS	51
Data Use Agreement	DOHS, IRS, OPM, Peace Corps, SSA, VA, CMS, HHS	8
Level of State Participation in FFE or SBE	36 States (33 original FFM and 3 late adds to the program), CMS	37
Computer Matching Agreement	DOHS, IRS, OPM, Peace Corps, SSA, VA, CMS, HHS	8
Business Service Agreements	DOHS, IRS, OPM, Peace Corps, SSA, VA, CMS, HHS	8
Operational Readiness review	CMS, QSSI, CGI	3
Total Clearances		**185**

The table shows that there were 185 total organization agreements needed in order to implement a working Healthcare.gov website. More research would show an even greater degree of complexity if the perspectives of the individual actors and groups outside the government (i.e. Private Health Insurers) were included in this analysis. From this broad structural perspective, the 185 agreements each represent a possibility for failure or delay. In such a complex and contentious action as the implementation of the ACA, it is impossible to establish a probability

of a positive outcome for any specific agreement but it may be possible to highlight the complexities' effect on the overall implementation of the project. Following Pressman and Wildavsky's example of assuming the best for each agreement and "err(ing) on the side of agreement and good will" (P&W 107), Table 4 below shows the overall probability of a successful implementation based on the 185 total agreements and a very high probability of agreement at each decision point.

Table 4 **Probability of Success**

Number of Clearances	Probability of Agreement at each Clearance Point	Probability of Success After 185 Agreements
185	80%	0.00000000000000179%
185	90%	0.0000003426606593922%
185	99%	15.57797492867110000000%
185	99.9%	83.10273589761740000000%

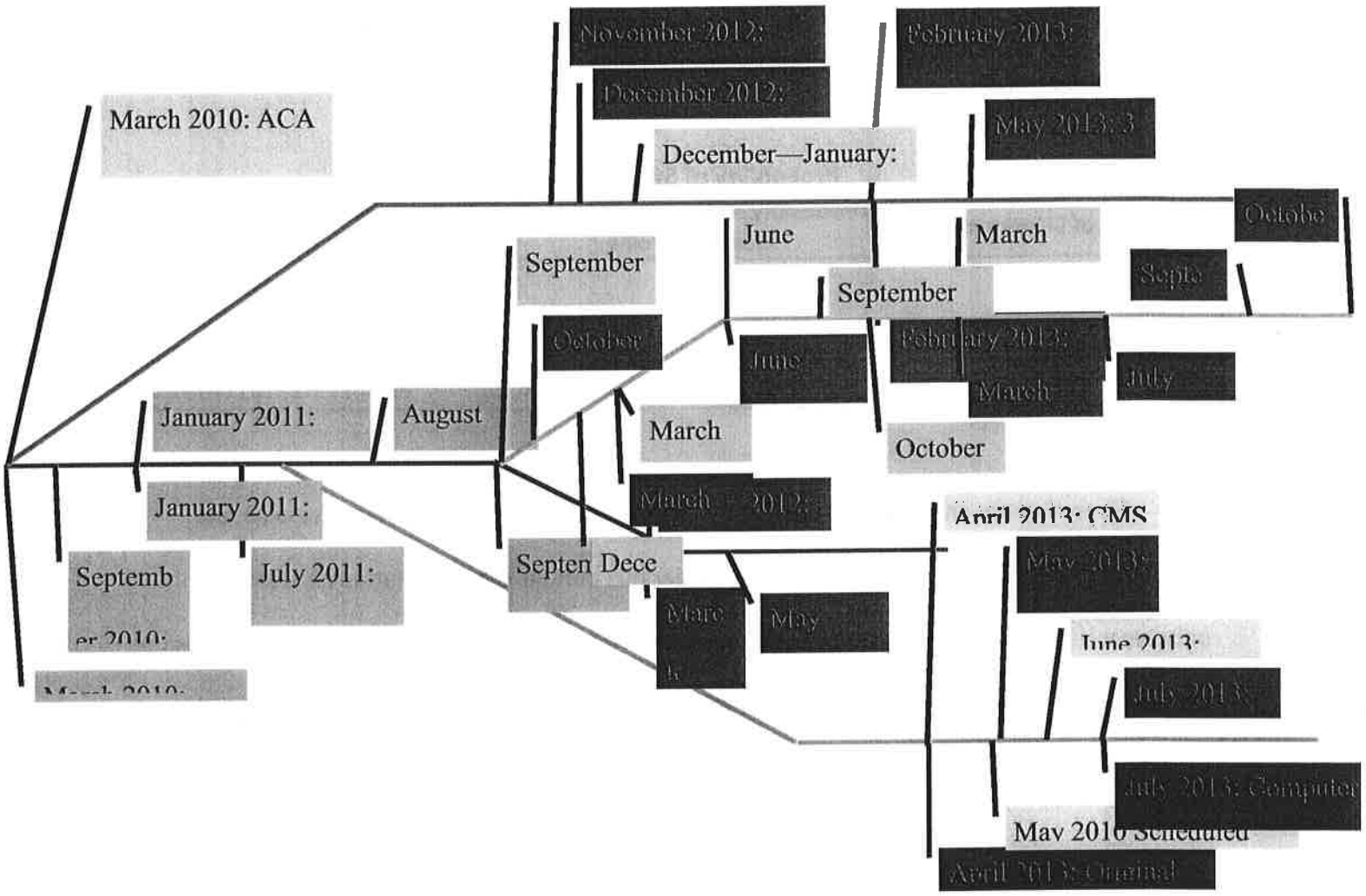
Even if every clearance outlined above had a 99% probability of a positive outcome (without failure or delay), the whole project under this current implementation structure would only have a 15% chance to have a perfect implementation. Given this information we can assume that the 185 clearances built into the structure of the Healthcare.gov website did have the ability to hinder the implementation.

The next question is: did the probable delays inherent in such a complex implementation structure delay the project to the point where it affected the outcome? The ultimate failure of the website was preceded by numerous delays in all groups involved in the implementation.

As the implementation process became more complicated, there was a significant increase in the number of delays. Implementation is the ability to achieve the desired results through a causal chain of actions. As Figure YY below shows, the causal chain was disrupted.

The early delays may have caused the later delays among other areas of implementation. Figure 7 highlights the delays during the implementation process.

.Figure 7 Delays in the Implementation of Healthcare.gov



Conclusions and Recommendations:

The research has shown that there was a lot of complexity in the implementation of the ACA. It is an oversimplification of the situation to place blame on one public administrator or even one group. The record shows that national level implementation is difficult and as Pressman and Wildavsky noted, "it's amazing anything gets done at all." This research focused on two things: the structural limitations to the implementation of Healthcare.gov and the extent to which those limitations contributed to the initial failure of the website. Yes, the complexity inherent in such a large cooperative system was a limitation built into the structure of the website's implementation. There was a need for many groups of actors to give clearances before the project could progress. Every necessary step adds another possibility for delay and every delay decreases the probability for final success. Yes, the structural limitations to implementation contributed to the failure of the website.

The implementation of the ACA was not hindered by what Pressman and Wildavsky would call long causal chains, because most of the implementation was the responsibility of just two government agencies, HHS and CMS. It was the complexity and the extra clearances necessary for progress that hindered the implementation. Early in the policy making process the implementation was also hindered by the politically charged atmosphere, slowing down the rule making process and the process by which states chose to participate in the program.

In order to fully understand the implementation of Healthcare.gov, future research should focus on the effect individual public administrators had on the process. It would be beneficial to understand the attitudes of the administrators who held up clearances and caused delays. This study looked only at the structure of the implementation; as in past research, it would benefit

greatly from a bottom up approach that looked at the implementation ability of street level bureaucrats. Understanding how negotiation played a role in adapting the policy to the individual needs of the people it was designed to serve. In this instance, it would be interesting to see what drove the changes to the FFM agreements. It would also to be interesting to understand the changing requirements that came from the other federal agencies and what their concerns were that caused the delay in that group.

This value in this research has been to display the complexity that was inherent in the implementation process and its probability to cause delays. The hope would be to change the discussion from individual failure, to better thinking about the structure of policy and the implications of political decisions on the eventual outcomes. The GAO report places the blame on the shoulders of the CMS and HHS administrators who were responsible for the implementation and they should shoulder some of the blame. They were given a job to have the marketplaces and the website ready on October 1 and that didn't happen. However, it is important to understand how complex a job they were given so future programs can be more successful. Limiting decision points, reducing clearances, and simplifying complexity are proven structural ways to ease policy implementation. It falls to the policy makers and administrators to reconcile these facts within a complex democratic system.

References:

Barrett, M. S. (2004). Implementation studies: Time for a revival? personal reflections on 20 years of Implementation studies. *Public Administration,* 249-262.

Bowen, E. (n.d.). The pressman-wildavsky paradox: Four addenda or why models based on probability theory can predict implementations success and suggest useful tactical advice for implementers. *Journal of Public Policy,* 1-30.

Dye, T. R. (2011). *Understanding public policy*. Boston, Mass.: Longman.

Hill, M., & Hupe, P. (2003). The multi-layer problem in implementation research. *Public Management Review, 5*(4), 471-490. doi: 10.1080/1471903032000178545

Hupe, P. L. (2010). The Thesis of Incongruent Implementation: Revisiting Pressman and Wildavsky. *Public Policy and Administration, 26*(1), 63-80. doi: 10.1177/0952076710367717

Implementation of the affordable care act's exchanges and medicaid expansion, 113th Cong. (2012) (testimony of Cythia Mann).

Implementation of the affordable care act's exchanges and medicaid expansion, 113th Cong. (2012) (testimony of Gary Cohen, JD).

The Kaiser Family Foundation. (n.d.). Retrieved from http://kff.org/

Mazmanian, D. A., & Sabatier, P. A. (1983). *Implementation and public policy*. Glenview, IL: Scott, Foresman.

Paitien protection and affordable care act; Establishment of exchanges and qualified health plans; Exchange standards for Employers; Final Rule and Interim Final Rule, 77 Federal Register § 45 CRF Parts 155, 156 and 157 *et seq*. (2012).

Patient protectin and affordable care act; Data collection to support standards related to tessential health benefits; Recognition of entities for the accreditation of qualified health plans, 77 Federal Register § 45 CRF Part 156 (2012).

Peters, B. G. (2014). Implementation structures as institutions. *Public Policy and Administration, 29*(2), 131-144. doi: 10.1177/0952076713517733

Pressman, J. L., & Wildavsky, A. B. (1984). *Implementation: How great expectations in Washington are dashed in Oakland: Or, why it's amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes.* Berkeley: University of California Press.

United State of America, Government Accountability Office. (2013). *Partient protection and affordabile care act: Status of CMS efforts to establish federally facilitated health insurance exchanges.*

United State of America, Government Accountability Office. (2014). *Healthcare.gov: Ineffective planning and oversight practices underscore the need for improved contract management.*