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MANAGING HEALTH REFORM

A TURBULENT OPPOSITION

The ACA and the South

August 2014

Rockefeller Institute of Government
State University of New York

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State-Level Field Network
Study of the
Implementation of the
Affordable Care Act

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The ACA and the South

Introduction

The South is often been portrayed as being resistant to “Obamacare.”¹ It is from many of these states that legal challenges were filed against the Patient Protection and Affordable Care Act (ACA) after its enactment. Rather than operate their own exchanges, many southern states have defaulted to the federal health insurance exchange. Most have refused or deferred on Medicaid expansion. Table 1 on the next page summarizes the status of southern state actions on both of these policy options. Some states have employed obstructionist tactics to complicate enrollment assistance provided by navigators and others. Considering that many of the ACA’s provisions are most beneficial to states with health disparities stemming from lack of insurance coverage, limited access to health services, and high levels of chronic disease and poor health conditions – essentially a profile of much of the South – it would seem that these states would embrace the new law.² Yet many states have not done so. What accounts for this posture? Electoral politics and ideological differences among the parties certainly play roles. But as our preliminary research indicates, there are other factors as well that reflect ambivalence, caution, and uncertainty about state administrative and fiscal capacity, health demographics, and market conditions.

Through the review of nine state-level field reports conducted under the auspices of the *Managing Health Reform* research network and through analysis of other relevant literature and data, this report concentrates on the intensity and sources of opposition within the southern states towards the ACA. In referring to the South, we mean those sixteen states that comprise the U.S. Census Bureau’s definition of the region. The research network currently has researchers in twelve of these states.³ We find the opposition varies among southern states in degree as well as in rationale and

Table 1. The Southern States

	<i>Medicaid Expansion</i>	<i>Exchange Type</i>	<i>Research State?*</i>
Alabama	N	F	Y
Arkansas	Y	P	Y
Delaware	Y	P	N
District of Columbia	Y	S	N
Florida	N	F	Y
Georgia	N	F	Y
Kentucky	Y	S	Y
Louisiana	N	F	Y
Maryland	Y	S	Y
Mississippi	N	F	N
North Carolina	N	F	N
Oklahoma	N	F	N
South Carolina	N	F	Y
Tennessee	N	F	Y
Texas	N	F	Y
Virginia	N	F	Y
West Virginia	Y	P	Y

* As of June 1, 2014.

motive. There may be competing perspectives of what is “wrong” with health care reform and what the appropriate policy responses should entail. Both public officials and private interests are weighing in on the core features of ACA, namely Medicaid expansion and health insurance exchanges. The scope of debate and discourse includes the merits of policy intent and design. It also includes differences of opinion regarding how the new law is to be implemented and adapted to changing conditions. Most importantly, the situation is in flux with the possibility of future policy decisions departing from earlier oppositional positions. This report examines this turbulent situation in the context of: 1) politics and partisanship, 2) past history and administrative capacity, and 3) underlying market and demographic factors.

The Partisan Dimension of ACA Opposition

The most convenient explanation for the South's opposition to the ACA is found in electoral politics and partisanship. The South is dominated by red states as reflected in presidential voting patterns, party identification, elected state offices, and majorities in state legislatures. The region is a hotbed of tea party activism.⁴ In some states where Democrats are well entrenched, like Kentucky and West Virginia, the main wings of the party tend to be conservative and seek to keep Washington at arm's length. Our field research suggests that political opposition is not uniform.

Opposition takes different forms. Some critics appear to be resolute in their positions — convinced by ideological principle, pragmatic consideration, or a mix of both. Others appear to have conditional concerns about the ACA and seek reassurance that the risks of action (or inaction) are minimized.

Texas stands out as a particularly strident oppositional state. It looms large in the national landscape and its well-known Republican governor, Rick Perry, has gained prominence due, in part, to his criticisms of "Obamacare" as "big government." To the casual observer, one might think that the governor speaks for the state with one voice. Our field research suggests a more complex dynamic at work. For example, while the governor has been forthright in his opposition to Medicaid expansion, there has been some legislative consideration of a "Texas solution" to allow federal funds to be used to subsidize the purchase of insurance in the exchange by those newly eligible for Medicaid. Patterned after initiatives in other states, such as Arkansas, this legislation has not moved forward, but it did enjoy bipartisan support in the Texas House and had the endorsement of the Texas Association of Business.⁵

There may be no better example of partisan turbulence than that found in Florida. Its Republican governor, Rick Scott, is a former health executive and is well-known at the national level for his opposition to "Obamacare." Both the governor and legislative leaders opted against developing an exchange or expanding Medicaid when the ACA was signed into law. In 2010, Florida's Republican attorney general at the time was one of the first to bring suit against the ACA, eventually leading to a Supreme Court challenge. The Court's decision upheld the basic architecture of the ACA while giving states the choice to expand Medicaid. As our field research recounts, Florida's initial response displayed some cracks in partisan unity. The governor initially held that the state would not operate an exchange and would not expand Medicaid. Legislative leaders, while also oppositional, signaled to the U.S. Department of Health and Human Services (HHS) secretary that the governor did not necessarily speak for the state as a whole. However, the governor changed his mind a few months after the Supreme Court decision and supported expansion. But the House speaker opposed it vehemently and successfully.⁶

Further contributing to political turbulence is the electoral cycle. Elections do and will matter. A case in point can be found in Virginia. As our field research reveals, there was considerable opposition to the ACA from 2010 through 2013 and this was shared by state legislators, the governor, and the state attorney general.⁷ In winter 2014, Democrats regained the governor's office. Governor Terry McAuliffe wanted to reverse course and expand Medicaid. Considerable debate occurred during the spring 2014 legislative session and the governor met stiff resistance from conservative legislators. The governor is now exploring executive options.

Arkansas, Kentucky, and West Virginia all provide good illustrations of the dynamics at work in oppositional politics. Each of these states has elected to expand Medicaid. In each case, the decisions were arrived at only after considerable deliberation and maneuvering to satisfy or avoid resistance from conservative interests. In Arkansas, a bargain was reached between the Democratic governor and a largely Republican state house by securing a federal waiver called the "private option" to allow Medicaid funds to be used to buy private insurance in the health exchange for newly eligible groups. However, this agreement has been fragile and its continuation was barely approved for the 2015 fiscal year.⁸

In West Virginia, the state's conservative Democratic governor lined up support from the West Virginia Hospital Association and waited for the end of the legislative session before taking executive action to expand Medicaid. He also secured support from the state's U.S. senators (Jay Rockefeller and Joe Manchin), both Democrats. By all indications, there is now strong support for Medicaid expansion in West Virginia. The state legislature, dominated by conservative Democrats, has not challenged the governor's actions. While a similar path of executive action was pursued in Kentucky, the prospect for long-term support is more precarious. A Democratic governor made a strong push to expand Medicaid in the face of resistance from conservative state legislators. In addition, the state's U.S. senators (Mitch McConnell and Rand Paul), both Republican, have been vocal and visible in their opposition to Obamacare. The fortunes of reform may change as the governor exits office in January 2016.⁹

Our view of the South does not discount the partisan and political maneuvering that has been associated with the ACA and states' rights platforms. The tea party has made significant inroads in the South. Various conservative politicians with national viability have used their opposition to Obamacare to appeal to the core and broaden their base of recognition, if not support, among a potential electorate at the national level. Politicians such as Nikki Haley of South Carolina, Bobby Jindal of Louisiana, Rick Perry of Texas, and Rick Scott of Florida have become all but household names because of their opposition to President Obama generally and to the ACA specifically. Others, such as Virginia's

Bob McDonnell and Ken Cuccinelli, have exited the political stage, at least for now, with the shifting tides of state politics.

In brief, a closer look at the southern states reminds us that beneath the surface of what might appear to be resolute political opposition are countercurrents of difference and opinion. Those watching the South should not assume that nationally prominent politicians from these states necessarily represent all viewpoints, even those that are oppositional. Opposition to the ACA may stem from ideological perspectives, but may also be rooted in more conditional aspects of state-specific and institutional contexts. The strength and persistence of opposition may be checked by other state-level interests and actors.

State Governance Capacity and History: Another Dimension of ACA Opposition

In the study of federal policy implementation, it is inadvisable to assume that all states start from the same position when implementing new law. Medicaid expansion illustrates how the starting lines vary among states. The ACA provides funding incentives for states to expand Medicaid eligibility to adults, regardless of working or parental status, to 138 percent of the federal poverty level (FPL). Making the most of these incentives may be challenging from a fiscal and administrative standpoint. There are costs involved in supplementing existing arrangements, and concerns to be considered about long-term obligations once a decision has been made.

Traditionally, most southern states have been very restrictive in providing coverage to adults. Recent eligibility rules for working adults with dependents, the least restrictive pathway to Medicaid for those in this population, are illustrative. According to data collected by the Kaiser Family Foundation, as of January 2013 the income eligibility threshold for working parents of dependent children did not exceed 60 percent of the FPL in all of the southern states with the exception of Delaware (120 percent), the District of Columbia (206 percent), Maryland (122 percent), South Carolina (89 percent), and Tennessee (122 percent). In some states, the income eligibility limits were particularly restrictive, such as in Alabama (23 percent), Arkansas (16 percent), Mississippi (29 percent), Texas (25 percent), Virginia (30 percent), and West Virginia (31 percent). In all the states, the eligibility threshold for nonworking adults with dependents was a much lower percentage of the FPL. Coverage for adults without dependents was virtually nonexistent in most southern states, with the exception of Delaware; the District of Columbia; Maryland; and, in limited cases, Arkansas.¹⁰

Restrictive access to Medicaid may tell us something about state political cultures and attitudes toward the poor. But, in practical terms, it also tells us about the distance that states with restrictive guidelines must make up to expand Medicaid coverage to the poor. Those southern states that had been generally permissive have opted for Medicaid expansion (Delaware, the District of Columbia, and Maryland). In general, restrictive states have not.

The three outliers of Arkansas, Kentucky, and West Virginia provide helpful illustrations of the complicated factors involved in state policy choice.

Like other border states in the South (Delaware and Maryland) and the District of Columbia, both Kentucky and West Virginia decided to expand Medicaid. But unlike these places, they were not as well positioned to do so. Political will was lacking and administrative and fiscal ability was in question. As previously noted, expansion in both states resulted from gubernatorial action that anticipated potential and responded to actual political resistance from state legislators and others. In both cases, arguments to expand Medicaid were shored up by cost-benefit and actuarial analysis that indicated the advantage of adopting the option. In both cases, decisions to expand Medicaid were delayed not only by political considerations but also by the need to marshal more evidence that expansion would be beneficial. Earl Ray Tomblin, West Virginia governor and past state Senate president, had encountered Medicaid funding crises in the past and was very cautious about the unforeseen costs of expansion. He had to convince himself as well as others.¹¹

As mentioned previously, Arkansas has pursued a “private option” approach to Medicaid expansion, which allows Medicaid dollars to be used for the newly eligible to purchase insurance through the health exchange. Support has ebbed and flowed in Arkansas. But the approach has the attraction of providing a political middle-ground for compromise and it is seen as a controlled measure that minimizes state financial risk. It is not surprising that other southern states such as Florida, South Carolina, Tennessee, and Texas have actively investigated the private option model. It has also attracted attention from other states beyond the region. The attractiveness of the approach is in its appeal as a private sector solution to a public sector challenge. Rhetorically, it provides a political out for conservatives who might have been ostensibly steadfast in their opposition to expansion. But, in practical terms, there is another attraction. By shifting management primarily to private insurers, administrative costs can be minimized in state Medicaid bureaucracies. Perhaps more importantly, the private option can be framed as a temporary and contingent program. If formally made part of a state’s Medicaid program, the expectation of continued coverage for newly eligible groups might become deeply seated. This might prove problematic if program costs became unpopular or untenable. In short, the private option creates a theoretical exit strategy that soothes the worries of those who might think that expansion is an open-ended commitment.

History makes a difference as well. In Tennessee the ambivalent posture towards Medicaid expansion is best understood in the context of its recent past. The state was an early pioneer in Medicaid managed care, called TennCare, and in using the program as a platform to extend coverage to low-income adults and

children. In the 1990s and early 2000s, budget shortfalls created significant problems, and those painful memories are still fresh, especially as the state faces continuing fiscal problems.¹² Other states in our sample, including South Carolina and Texas, have faced past Medicaid budgetary crises, which no doubt have contributed to cautious and risk-averse postures toward expansion. Budgetary risk was also important in Florida.¹³ Having been burned in the past with Medicaid funding crises, current state tendencies to be “twice shy” are understandable.

However, with time new dilemmas appear vis-à-vis deferring Medicaid expansion. The most immediate involves pressures on hospitals and other providers for charitable care amid limited funds to offset these costs. With the ACA’s Medicaid expansion provisions, publicly funded charitable care compensation, most notably disproportionate share hospital (DSH) payments, are being phased out. Hospitals and their trade associations in a number of states have been vocal in their support of Medicaid expansion, or some variant thereof, such as the private option. Our field reports note that this has been the case in Alabama, Florida, South Carolina, and Texas.

A further quandary emerges when state governors and legislatures are criticized by various stakeholders for leaving money on the table offered through expanded Medicaid funding. By foregoing federal Medicaid dollars, these actors may be seen as putting politics before practicality in addressing health coverage and health cost issues in their states. Finally, there is the issue that the ACA’s premium subsidy structure was built on the assumption of universal Medicaid expansion. Now that it is an option, states not electing to expand are left with sizable populations that may not be able to afford insurance. This raises both practical economic and more philosophical social equity issues. The former deals primarily with stresses placed on health systems in providing uncompensated care for populations that would otherwise be covered under Medicaid. The social equity questions center on the “fairness” of working low-income families falling between the cracks of health coverage. Being neither too poor to qualify for Medicaid nor making enough income to qualify for subsidies, these families may have to pay the full premiums on insurance policies. Other analysis suggests that this coverage gap problem is especially pronounced in the South.¹⁴

Beyond partisanship and politics, state opposition or reluctance to embrace the ACA may be rooted in preexisting circumstances relating to past policy practices and experiences. This is especially evident in the case of Medicaid expansion. To be risk averse is not tantamount to being obstructionist. States that have restricted access to Medicaid in the past may be especially cautious about expanding the program. With time, we are seeing oppositional stances modified as state leaders search for alternative mechanisms, such as the “private option,” to extend benefits while minimizing state exposure to financial liabilities.

Markets and Demographics Influence the Dynamics of ACA Opposition

For those who sell, are covered by, or are reimbursed by insurance, the ACA is a reality. Insurance carriers have responded to the law by revising policies to conform to new federal standards and by making decisions as to whether to participate in exchanges. Health care providers are aware of the opportunities and challenges involved as insurance coverage is extended to more individuals. Public interest groups and advocates are engaged as well, concerned about access to insurance for both the general population and specific groups affected by health conditions or geographic disadvantages. Our view of the South illustrates how these nongovernmental stakeholders are shaping the ACA's implementation and the health care reform experience in general. Our research also highlights how existing markets and demographic factors are shaping state responses to health care reform.

Just as the issue of Medicaid expansion helps to illustrate how delay and refusal reflects not only politics but also administrative and historical contexts, state experiences with exchange deliberations and decisions also tell us that there is more to the equation than just politics. No doubt, politics has influenced decisions to reject Obamacare, resulting in states reversing course on exchange intentions and refusing to expand Medicaid. But what is also notable in our field research are the market and demographics forces that have shaped this behavior. Just as notable are the private interests that are acting to counter partisan obstructionism in those few states where concerted efforts have been made to thwart consumer participation in the health insurance exchanges.

Currently, only two states in the South operate their own health insurance exchanges, Kentucky and Maryland. The District of Columbia also operates its own exchange. Arkansas, Delaware, and West Virginia operate state-federal partnership programs. The remaining southern states have defaulted to the federal exchange system. Initially, a number of states signaled a preference to establish health insurance exchanges. This included highly oppositional states such as Alabama, South Carolina, and Virginia. As the field research suggests, the primary reason for this initial stance was a desire to retain some level of state autonomy in insurance regulation. Beyond states' rights rhetoric, health insurance has long been a domain of state regulatory authority.

The reasons why these and other states backed away from the state option reflect a complex mix of political, administrative, demographic, and market concerns. From our field research, we found that politics played a big role in South Carolina. While a special commission recommended against a state exchange due primarily to fiscal reasons, the governor's vehement opposition to the ACA seemed to have shaped deliberations.¹⁵ Similarly in Virginia, a preference to exert state control over the proceedings appeared to be replaced by a desire to distance state elected officials

from “Obamacare.” Initially, the state exchange option had both the support of a special government commission and the Republican-dominated general assembly. However, shifting political attitudes, which hardened conservative views that the ACA was unconstitutional, resulted in no final action and a default to the federal exchange system.¹⁶ But concerns over administrative cost and market realities also played a hand. Our field research suggests that considerable attention was given to the potential costs of state program management in such states as South Carolina, Texas, and West Virginia. We also found that these cost projections were contested by various interests. For example in South Carolina, a coalition called Accept ME (Medicaid Expansion), challenged state government cost estimates that suggested Medicaid expansion was too financially risky and a poor investment in health care coverage. Accept ME had broad-based representation, including social justice advocacy groups, the state chapter of AARP, the South Carolina Healthcare Association, and others.¹⁷

Among the states, West Virginia provides one of the clearest examples of the use of analysis in decision making. The state backed away from operating its own exchange for a variety of reasons. After gathering considerable actuarial data on the insurance market, the state determined that the viability of a competitive market was limited. It projected that relatively few new uninsured would be covered in the exchange, with most gains coming from Medicaid enrollment. Establishing a state exchange was not seen as prudent use of state resources. The state also found that building and maintaining information technology infrastructure was cost prohibitive. In the end, West Virginia elected to form a weak state-federal partnership for its exchange. The state relied almost entirely on federal administration of its marketplace, opting to play a minimal role in oversight and taking a hands-off approach to exchange marketing and outreach.¹⁸

It is significant that in a number of southern states, especially those with substantial rural populations, the individual health insurance market is less than ideal. The markets are dominated by relatively few carriers. Often these are nonprofit Blue Cross Blue Shield plans. The relatively poor health profile of the population is unattractive to insurers. So, too, is limited health care delivery capacity. Disproportionately low-income and aging populations result in much of the insurance payer mix being dominated by Medicaid and Medicare. In such circumstances, insurers have relatively little leverage in negotiating pricing with providers who are motivated to offset the low reimbursement rates associated with publicly funded insurance programs. Faced with these prospects, some states were wary about taking on the responsibility of impaired markets that might not attract competing insurance programs. This could be perceived as a recipe for disaster, leaving state officials accountable for the failure of a new federal law.

The first year of implementation has borne out some of these concerns. In West Virginia, only one carrier participates in the health exchange. In Alabama only one carrier issues policies in all counties. In only four Mississippi counties do consumers have a choice of more than one insurance carrier. While premiums in both Alabama and West Virginia are at or near national averages, in Mississippi the costs are far above the norm. A federal analysis of insurance costs weighed the average cost of “bronze” coverage across the states. The average monthly premium for lowest-cost bronze coverage was \$249; in Alabama the cost was \$247 and in West Virginia the cost was \$280, while in Mississippi the cost was \$342. A similar trend holds for “silver” and “gold” plans.¹⁹

Within the South, two states and the District of Columbia operate their own state-based exchanges. As our field report suggests, in Maryland this decision was guided by the state’s “progressive” history of promoting health reform and extending Medicaid benefits to qualified populations.²⁰ In Kentucky, the Democratic governor drove the decision-making process in the face of stiff opposition from statehouse Republicans. Our field research suggests that the support of major state-level insurance companies was key to the adoption of the state exchange option. Though Kentucky has garnered positive attention in the operation of its exchange and in expanding Medicaid, there are concerns that without a legislative mandate, actions could be reversed in the future.²¹

With the ACA’s rollout, there have been reports about oppositional states in the South and elsewhere employing obstructionist tactics to thwart program implementation. Our field reports from Florida and Texas, for example, discuss state government actions aimed at complicating the certification of federally funded health insurance navigators and assistors. In Florida, legislation mandates that navigators undergo background checks, submit fingerprints, and pay an application fee for licensure. Our field researchers note that this apparently contributed to few licensure applications. In addition, the governor ordered the state’s health department to prohibit navigators from being stationed in county health departments.²² In Texas, the governor directed the state’s insurance department to require navigators to attend trainings, to be tested on their knowledge, and to submit to background checks. In some instances, this led organizations to abandon efforts to participate as navigators.²³ A similar situation emerged in West Virginia, where the state attorney general, acting independently of the governor, opened inquiries into the hiring and personnel practices of organizations that had received navigator grants. As a result, one organization turned down a \$365,000 federal grant.²⁴

But there are countercurrents to these actions. Even in oppositional states, there is commitment by some stakeholders to encourage enrollment in either the individual insurance market or in Medicaid. These stakeholders include insurers; health care

providers; patient and consumer advocacy groups; and, in some cases, local governments. For example, in Texas, statewide coalitions have been formed to encourage enrollment. Local coalition activities are especially important to education and outreach efforts. Local governments have also been involved in outreach activities. These include major cities such as San Antonio and Houston.²⁵ In South Carolina, our field researchers note that the governor has directed state agencies to “follow the letter of the law” and to go no further in enabling health care reform implementation. As a result, the federal government is working more closely with local coalitions to advance implementation.²⁶ In Florida, local officials in three large urban counties challenged the governor’s order banning navigators from county health departments. One county commissioner drew parallels to the civil rights struggles of the 1960s.²⁷ Indeed, the emerging linkages between local governments and community organizations with federal agencies is somewhat reminiscent of the “creative federalism” of the 1960s when oppositional state governments were bypassed in order to advance federal-level social welfare and civil rights policies. Federal funding for navigation activities is helping to sustain collaborative local-federal arrangements. The fact that many of the navigator initiatives focus on minority and low-income populations is another echo of the past.

The specific interests of health care stakeholders are also evidenced in the navigator and assister practices and priorities. Across the South, we see that these intermediaries often focus on specific populations. In addition to minorities and low-income groups, these include expectant mothers; those with chronic diseases; and specific geographic populations, both urban and rural. For example, in Alabama one navigation grant is focusing on the poor in the state’s economically distressed Delta Region. Similarly in Kentucky, one navigator grant focuses on the state’s Appalachian counties. Much of the work of navigators and assisters is in outreach, informing and educating individuals about the availability of health insurance and Medicaid. However, our field research also reveals that grants are being awarded to navigators focusing primarily on those with medical needs who are encountering the health system. In West Virginia and South Carolina, navigators have been stationed at hospitals and clinics to direct the uninsured to coverage options. This continues a long-standing practice in hospitals where firms are retained to facilitate insurance enrollment in order to offset uncompensated care liabilities.²⁸ One implication of this approach is that those seeking acute care in these settings are likely to be low-income and may be directed to Medicaid programs. In states that are expanding Medicaid, such as West Virginia, this may help with overall enrollment efforts. In nonexpanding states, such as South Carolina, this may put some upward pressure on the state to revisit its position on Medicaid expansion.

In Kentucky, the individual insurance market and hence the exchange are dominated by relatively few insurers that prevail in

their own regional markets. Our field report from the state also notes that these major carriers have been active in policy discussions and in participation on various advisory groups and commissions. They know that their own interests are at stake. As our researchers noted, these insurers “have a clear understanding that successful implementation brings them tens of thousands of new health plan members, and that shaping systems to minimize market disruption will avoid excessive administrative costs.”²⁹ Our field reports from Alabama, South Carolina, and West Virginia suggest that the ACA may strengthen the hand of existing insurers that dominate the individual market. In each of these states, Blue Cross Blue Shield (BCBS) plans are the major insurers. In West Virginia, BCBS is the only insurer in the exchange. In Alabama, BCBS is the only insurer that offers policies in all of the state’s counties, while another insurer offers policies in selected urban areas. A similar situation exists in much of South Carolina. In Florida, BCBS has been a major participant in and supporter of the exchanges.

Health care reform is more than politics; it’s about fundamental economics that affect insurers, health care providers, consumers, and taxpayers. Market conditions and demographic realities can help account for some of the oppositional turbulence that has emerged in the states. Uncertainty about the viability of markets and the ability of states to effectively manage exchanges may be contributing to opposition. The ACA may help to restructure the insurance industry by strengthening the hand of dominant carriers, especially in rural states.

The Big Questions Going Forward

Opposition to the ACA is neither uniform nor one dimensional. A view from the South illustrates the complexities and contingencies involved. The importance of our first look is that it sets the stage for further longitudinal analyses of what is happening in our federal system. The realization that opposition can take many forms and is shaped by factors beyond partisanship is worth considering, not only relation to the South, but for the nation as we move forward in ACA implementation. Our preliminary analysis suggests important questions for further consideration.

One important topic for investigation is the influence of the rural dimension on shaping and guiding state responses to health care reform. A number of southern states are heavily rural. In Mississippi and West Virginia, more than 50 percent of their populations live in rural areas. Other states, such as Alabama, Arkansas, and Kentucky, have more than 40 percent of their populations in rural areas.³⁰ Most other southern states have significant rural populations as well. The health demographics of many of these states are negative, with high incidences of chronic disease and generally older populations. Together, this has an impact on health care access and delivery, which is often limited in these areas. The payer mix in many of these states is tilted primarily to public sources such as Medicaid and Medicare. In short, in some

southern states the prospects of competitive insurance markets are limited. The same may hold for other parts of rural America.

Another important question will focus on how states adopt and adjust to the management of the ACA. The implementation experience thus far has been bumpy and illustrates how individual states and stakeholders respond to unanticipated consequences. A case in point can be found in controversies surrounding the cancellation of insurance policies in fall 2013. In the face of stiff criticism, President Obama backtracked on requirements that new policies adhere to ACA coverage guidelines. He deferred the matter to the states, many of which decided not to reverse tack. However, private decisions made by insurers helped shape the consequences that followed. Throughout 2013, insurers were allowed to practice early renewal, essentially preserving pre-ACA standards in coverage through most of 2014. In West Virginia, the dominant insurer, Blue Cross Blue Shield, opted to do this; in contrast, Alabama's major insurer, also a Blue Cross Blue Shield plan, decided against early renewal. In West Virginia, this meant that the cancellation controversy did not gain as much traction as elsewhere in the country.

Those who study politics know well that policy logic can be trumped by partisan passions. But over time, extreme positions, be they on the left or the right, will likely be tempered by the moderating influence of prevailing private interests. Ideological positions are rarely consistent or persistent when they are exposed to the practical realities of a pluralistic society and market economy. For example, the practical financial challenges that many hospitals and health care providers face may well prompt more rigid opponents of Obamacare to revisit their stances on Medicaid expansion. Partisan efforts to subvert enrollment through complicated regulations of navigators may be countered by health insurers and others encouraging enrollment of a new market of consumers. The ACA represents market reform. It involves the fortunes and interests of many well-established interests. In the months to come, we may expect even more turbulence as matters of practical finance and economics are more actively considered and perhaps accommodated.³¹

It will also be interesting to see how past policy deliberations and recent experiences inform future state actions. As our field reports note, many states engaged in detailed planning and assessment efforts in the lead-up to Medicaid expansion and exchange decisions. This includes states such as Alabama, Florida, South Carolina, Texas, and Virginia, which elected to default to the federal exchange and to defer Medicaid expansion. Political factors, coupled with uncertainties about regulatory, market, and administrative capabilities, contributed to these decisions. But as our field research and other analysis suggests, some of these states are reconsidering their options. Clearly, Medicaid expansion remains on the table for many of these states. Some of those in opposition are moderating their views by considering the private option as a

third way in what once was seen as a dichotomous choice. In Alabama, the path might take the form of adopting managed care delivery systems for the newly eligible.³² In Virginia, the election of a Democratic governor has changed the political dynamic, and there is considerable debate over the merits of whether or not to expand Medicaid. Exchange priorities may also be revisited. States have some level of flexibility in regard to the degree that they support or partner in exchanges primarily operated by the federal government. Previous deliberation and study may provide the starting point for future reassessment of state choices. States may seek to learn from others, as Maryland has been doing in trying to correct its troubled state exchange web portal. Others may reverse course, and this can cut both ways, as Oregon's recent decision to abandon its state exchange suggests.³³

The "wait and see" approaches used by some Southern states remind us that knowledge and evidence, whether it be comparative from other states or based on past experience, is crucial in building both political and practical guidance in moving forward with policy and program action. The South is not alone in this posture. One analysis of gubernatorial positions toward Medicaid expansion highlighted concerns about incomplete information in making hard decisions about expansion. Primary among these concerns involved potential burdens on state budgets.³⁴ Past program success may be an indicator of a state's willingness to try something new. As noted in a Rockefeller Institute of Government-Fels report of ACA implementation in Western states, past experience in program innovation and reform in health policy provided confidence in those states that moved ahead to expand Medicaid and establish state-operated exchanges.³⁵

Oppositional turbulence in the South suggests resistance to and criticism of the ACA comes from many different quarters and may be conditional rather than absolute. These states' experiences reveal that many different factors, both political and nonpolitical, such as market, demographics, and state capacity conditions, have helped to shape opposition to the ACA. These variables and conditions are not fixed. Oppositional turbulence is the product of differing perspectives and priorities at any one moment and across time. Future research will want to account for whether there is a persistence of opposition in the political and institutional context. This is of interest not only in regard to the South, but beyond. Election cycles, changing economic conditions, and stories of relative success and failure will all invite assessment of their influence on oppositional behavior. This is especially the case in considering the sources of opposition, be they public officials such as governors, state legislators, state attorneys general, and health and human services commissioners, or be they well-established private interests. Our preliminary research suggests that the implementation process has been dynamic and that events are ever-changing. Private interests may have a moderating influence on the tone and persistence of political opposition. A

major consideration here may be that key stakeholder groups will lack tolerance for highly partisan actions when bottom line concerns are at stake.

In short, a preliminary view of the South reveals that opposition to ACA is turbulent. There are different reasons and motives for opposition. Partisan and political factors clearly have influenced action and reaction. But so too have underlying factors relating to past state policy practices, administrative capacity, and existing market and demographic factors. While looking at the past will help us understand the current situation, perhaps the most interesting paths of inquiry are focused on the future and in the tracking of state responses and actions as the ACA plays out. Given the conflictive and complicated responses to the ACA across the country, the lessons from the South are likely applicable beyond the region.

Table 2. The Southern States Field Report Authors

Alabama	Michael A. Morrissey and Peter M. Ginter
Florida	Robert Crew, Carol Weissert, and William Weissert
Kentucky	Julia Costich and Glen Mays
Maryland	Jocelyn M. Johnston
South Carolina	Christina Andrews with Marissa Yingling
Tennessee	John Gnuschke, David Mirvis, and Cyril Chang
Texas	David Warner, Samuel Richardson, Elizabeth Colvin and students from the LBJ School of Public Affairs Policy Research Project.
Virginia	Kirk Jonas and Massey Whorley
West Virginia	Christopher Plein
<p>Christopher Plein would like to acknowledge the research contributions of the field report authors to this overview report. In addition, he appreciates the comments offered by various field researchers on earlier drafts of this report, as well as comments offered by Richard P. Nathan and Tom Gais.</p>	

Endnotes

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