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The Affordable Care Act: A User's Guide to Implementation

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INTRODUCTION

SHORT-TERM VS. LONG-TERM

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This month, the Obama administration began implementation of key elements of the Affordable Care Act (ACA) – an historic piece of legislation and the most significant domestic policy achievement of the Obama administration to date. Notwithstanding a number of delays in some parts of the law, and a rollout filled with a number of technology related problems, it is highly likely to remain the law of the land in spite of the fact that, in a rare departure from the norm, opponents of the law have kept up the fight years after passage by Congress. They have continued to try and prevent its implementation through a wide variety of tactics. The most recent and most dramatic was tying a provision defunding the ACA onto the continuing resolution to keep the government open and shutting down the government when the Senate refused to go along with one version of ACA roll-back after another. In addition, the House of Representatives has voted to repeal the bill more than 40 times, proposed to delay opening of the exchanges over privacy concerns, and proposed to delay implementation of the entire bill (or parts of it) by a year.

The highly politicized environment in which this law takes effect means that in the short-term people will see what they want to see. What we hope to do in this paper is to offer a balanced way of looking at the implementation of the law that takes us beyond today's political situation and outline some meaningful metrics for establishing success or failure (or both) in the years to come. We will describe the complex federal-state architecture of the law and how, in many states, politics have dictated the choices made. And then we will ask eight questions that will determine the *long-term versus the short-term* success or failure of the law. They are:

1. Is there a reduction in the total number of uninsured?
2. Is there an increase or stabilization in the cost of premiums on the exchanges and in the private market?
3. Are there an adequate number of plans in the exchange and does the number increase or decrease over time? Are plans exiting or entering the market over time?
4. Does the number of people who pay the penalty for not having insurance increase or decrease over time?
5. Is there a decline in employer coverage?
6. Is there a decline in full time-work and an increase in part-time work?
7. What is the extent of the conflict between federal and state oversight of health insurance and does it increase or decrease over time?
8. Is there evidence of an increase or a decrease in out-of-pocket expenditures on health care?

THE STRUCTURE OF THE PROGRAM

It's been a long time since the federal government had to implement a large, new federal program. Nearly ten years ago, we saw the implementation of Medicare Part D and the creation of a new cabinet department, the Department of Homeland Security (DHS). In each instance, there were predictions of disaster and substantial growing pains. In the case of Medicare Part D, implementation exceeded expectations and costs have not been nearly as high as feared. In the case of DHS, implementation was also bumpy. Nonetheless, ten years later both agencies operate more or less smoothly and, in retrospect, the crisis now seems overblown.

Earlier major pieces of health care legislation such as the Medicare law in 1965 and the Medicare Part D amendments in 2003 were the sole responsibility of the federal government. In fact, the bureaucrats at the Social Security Administration who were to have the responsibility for administering the original Medicare program were also closely involved in its design.[1] In the case of Medicare Part D, the "dual eligibles" (the poor elderly who qualified for both Medicare and Medicaid), presented considerable challenges to the states and federal government during the transition. But absent ferocious political opposition, those in charge of implementation were able to work out the problems. The implementation of Medicaid provides some guidance to what might happen to the ACA. The states did ultimately decide to participate in the program, resulting in the system we have today that varies enormously from state to state.

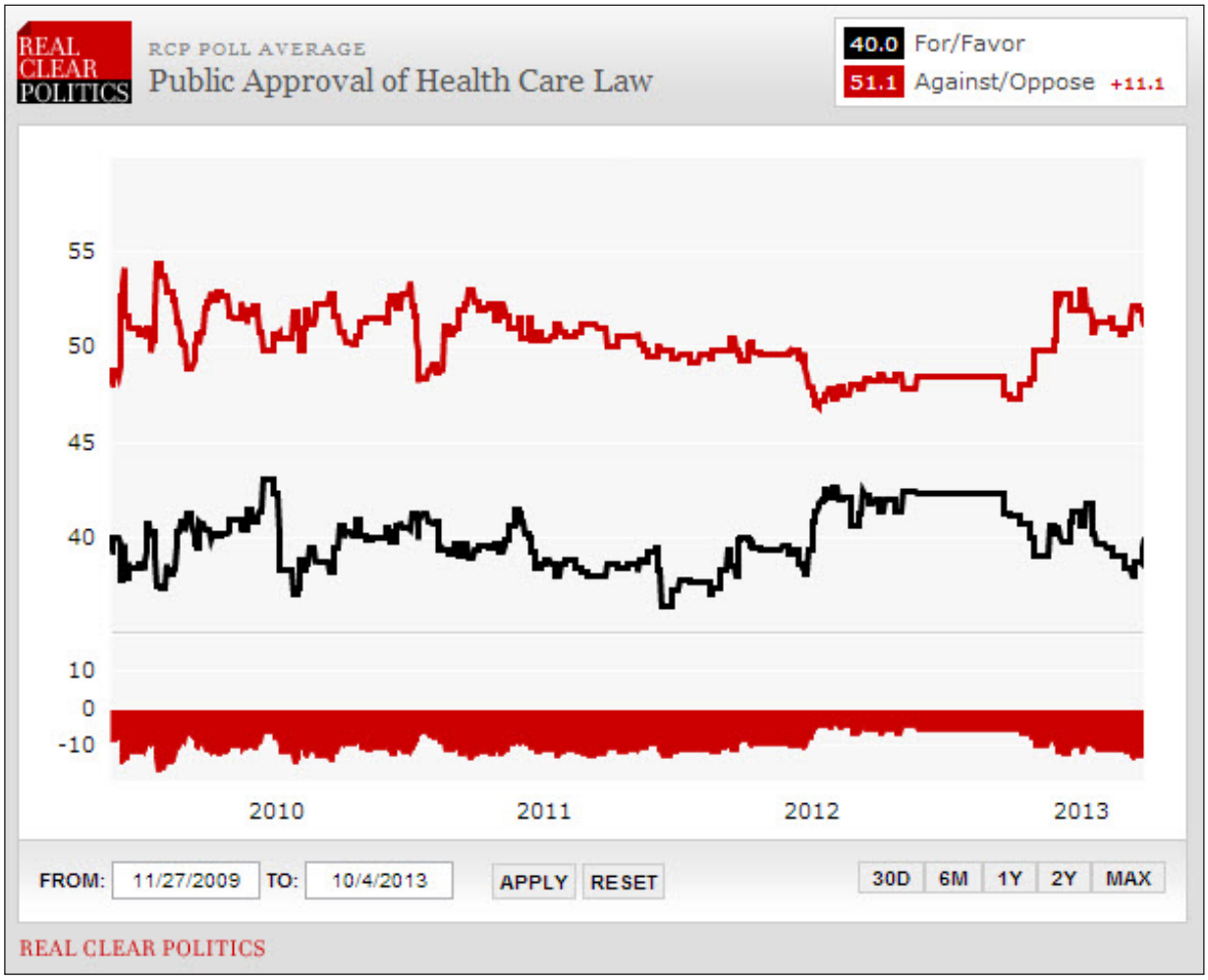
But compared to earlier pieces of health care legislation, the ACA involves yet another level of complexity; activity by 50 states, the jurisdiction of 50 state insurance regulators, 50 state

1 See Robert M. Ball, "Perspectives on Medicare," *Health Affairs,* Vol. 14, Number 4.

Medicaid directors, and changes in the entire health care industry. As Alice Rivlin has pointed out in an article for the Brookings website, if the ACA were really the sort of federal power grab that its opponents accuse it of being, implementation would be much less complex.[2]

Added to the inherent complexity of the bill is the fact that it had no Republican support when it passed. Since then, the situation hasn't improved. In spite of a number of insurance reforms already in place, such as the ability to continue coverage for children under 26 years of age, the prohibition on exclusions for pre-existing conditions for children and the limits on rescission authority, a large number of Americans have yet to see the full impact of the ACA. Moreover, the constant criticism of the bill means, as Graph 1 from RealClearPolitics shows, that at any given point in time for the past several years, it has been opposed by half or more than half of all those polled.

GRAPH 1



Accessed: October 4, 2013

2 Alice M. Rivlin, "Implementing the Affordable Care Act: Why is this so complex?" Brookings, July 8, 2013. Accessed at: http://www.brookings.edu/blogs/up-front/posts/2013/07/08-affordable-care-act-implement-health-rivlin

This heavily polarized backdrop will mean that attempting to judge success or failure will involve sorting through a variety of conflicting and highly partisan claims. In fact, reliable data on many of the items key to determining success will not be available in the short-run and, frankly, may be tough to measure over time. Thus, determining whether or not this legislation is working will occupy analysts for some time to come. All of this will be made more difficult because of the myriad of federalism issues inherent in the architecture of the legislation and the highly partisan climate in which implementation has begun.

In the first section of this paper, we will map the politics surrounding implementation choices that have been made by the states. In the second part of the paper, we will identify eight things to watch over time to begin to determine whether or not the bill is the success Democrats hope it will be or the failure Republicans predict it will be.

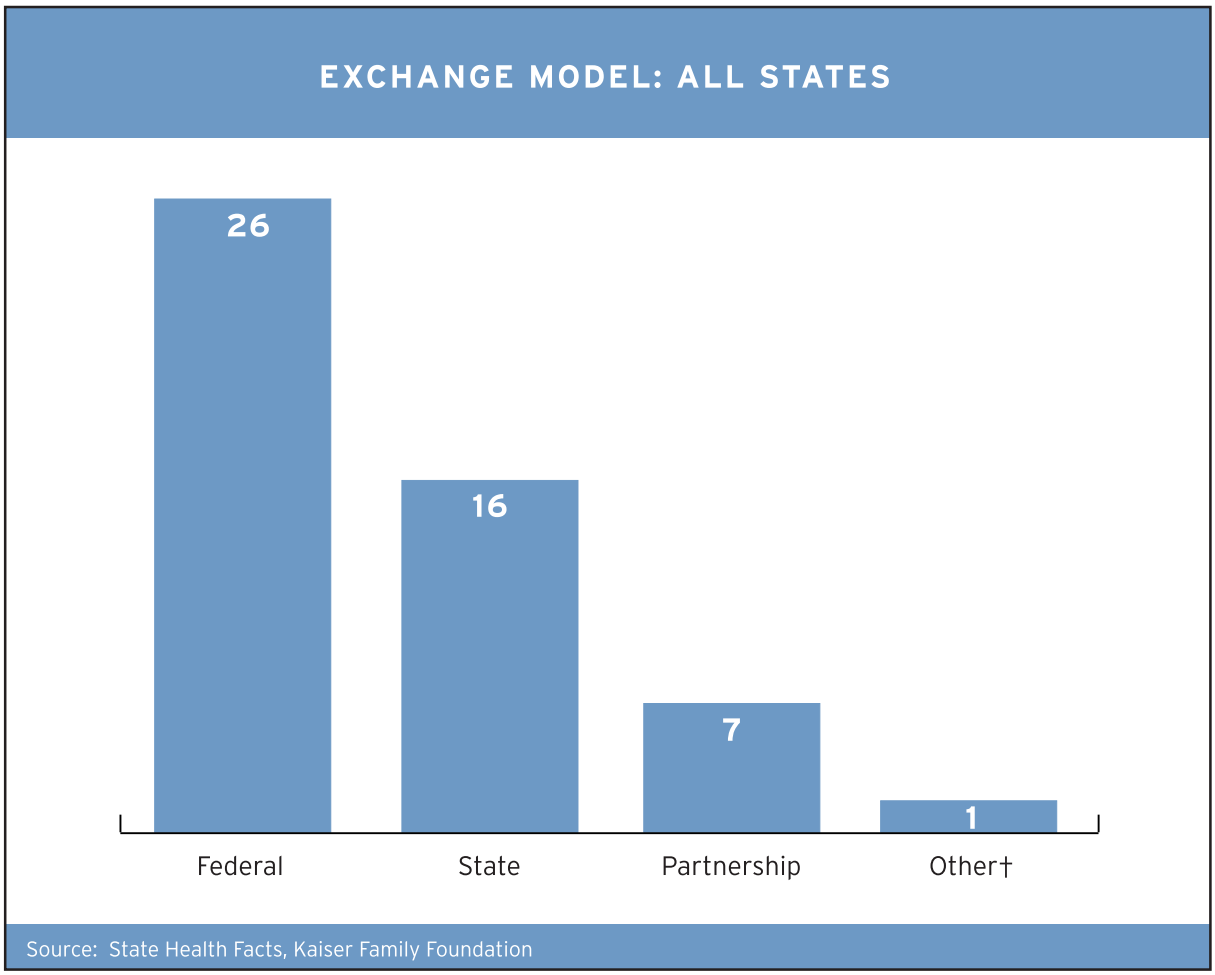
STATE DECISIONS

Unlike Medicare before it, the ACA has built into it a number of key decisions that were left up to states. Among the most important was the decision whether or not to create an insurance exchange. Another decision, whether to expand Medicaid coverage (or not) was not built into the law but came as a result of the Supreme Court's decision on it. When the bill was drafted, Congress assumed that all states would be required to expand Medicaid coverage to individuals up to 133% of the poverty line - but the Supreme Court ruled that that decision needed to be left to each state.

As most observers of the law know, not all states have decided to create a state exchange for individuals or one for small business (SHOP) for the purpose of providing a more affordable and uniform market for the purchase of health insurance. Many expected that states would create their own exchanges. As of September 2013, only sixteen states and the District of Columbia have set up their own exchanges. As Graph 2, illustrates, another seven states have set up what are called "partnerships" where they will share responsibility. Utah declined to implement an individual exchange, choosing to continue their state-based small business marketplace and leaving the individual market to the federal government. (Listed as "other" on the graph.) But the big news is that the remaining twenty-six states — or more than half of all states — declined to set up exchanges; leaving that work to the federal government.[3]

3 See Appendix 1 for a complete list of states and exchange type.

GRAPH 2

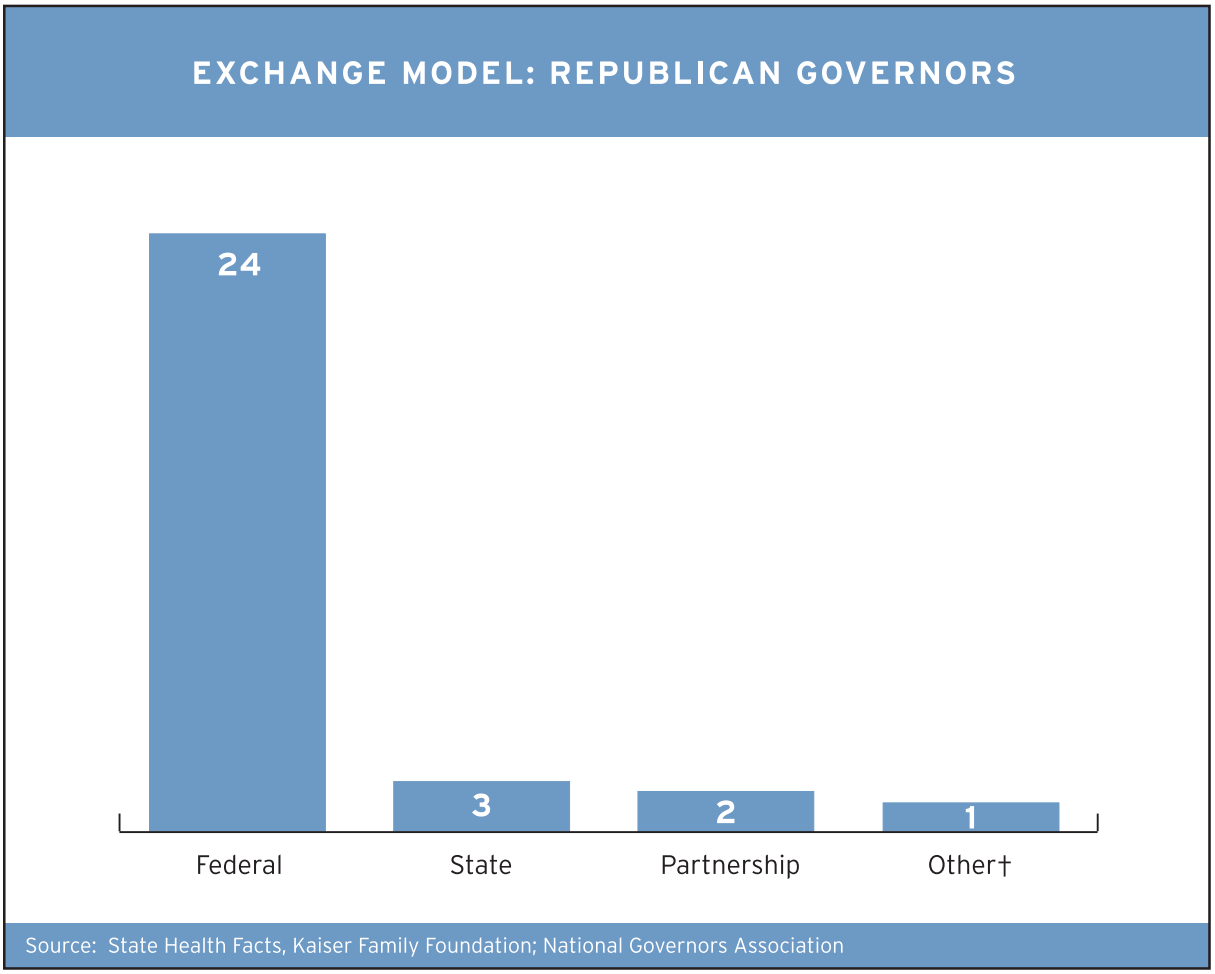


"States can create and operate their own marketplace (State-Based Exchange) or a hybrid called a State Partnership Exchange in which the state runs certain functions. A Partnership Exchange allows states to make key decisions and tailor the marketplace to local needs and market conditions. The Federal government will establish and operate a marketplace in those states that do not establish their own."[1]
†Utah will run a state Small Business Health Options Program (SHOP) with a federally facilitated individual exchange.[2]

1 State Health Insurance Marketplaces, The Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Service
2 See Appendix 1 for a complete list of states and exchange models

Given the polarized nature of the health care debate, it is not surprising to learn that the decision to create or not create an exchange was an overwhelmingly partisan decision. Graph 3 shows the choices of Republican governors when it came to implementation of the new law. Almost all the Republican governors chose to leave the operation of the exchanges to the federal government. The exception was Utah where, as indicated above, the governor decided to set up a small business exchange but leave the individual exchange to the federal government. In Iowa, the Republican governor opted for a partnership with the federal government as did the governor of Michigan. Nevada, Idaho and New Mexico were the only states where Republican governors opted to create a state-run exchange.

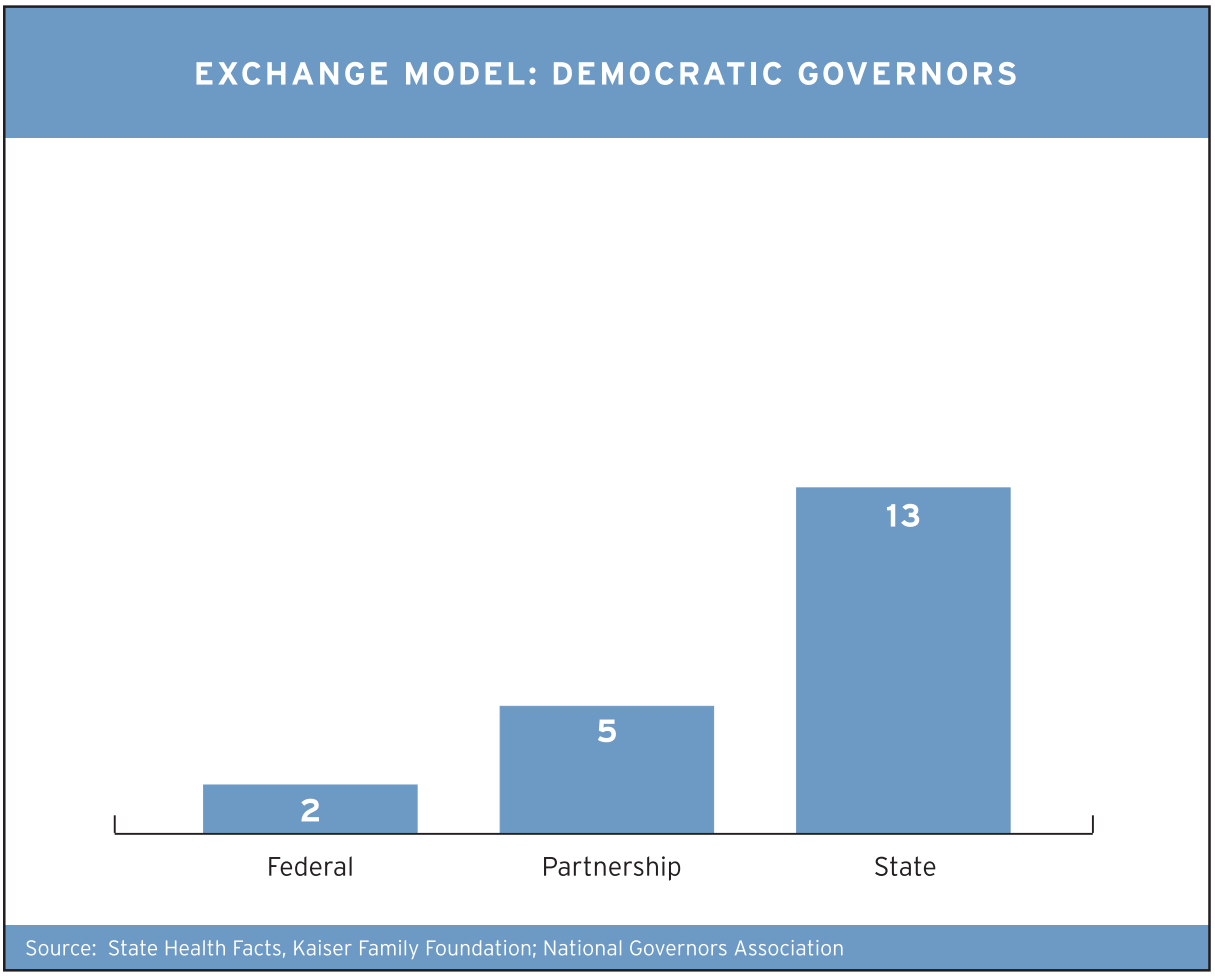
GRAPH 3



† Utah will run a state Small Business Health Options Program (SHOP) with a federally facilitated individual exchange

A look at the choices of Democratic governors yields almost exactly the reverse conclusion. Most of the Democratic governors opted to create their own state exchanges, as Graph 4 illustrates. The only states led by Democratic governors that opted for the federal exchange were Missouri and Montana. The remaining Democratic governors opted to create some sort of partnership with the federal government.

GRAPH 4

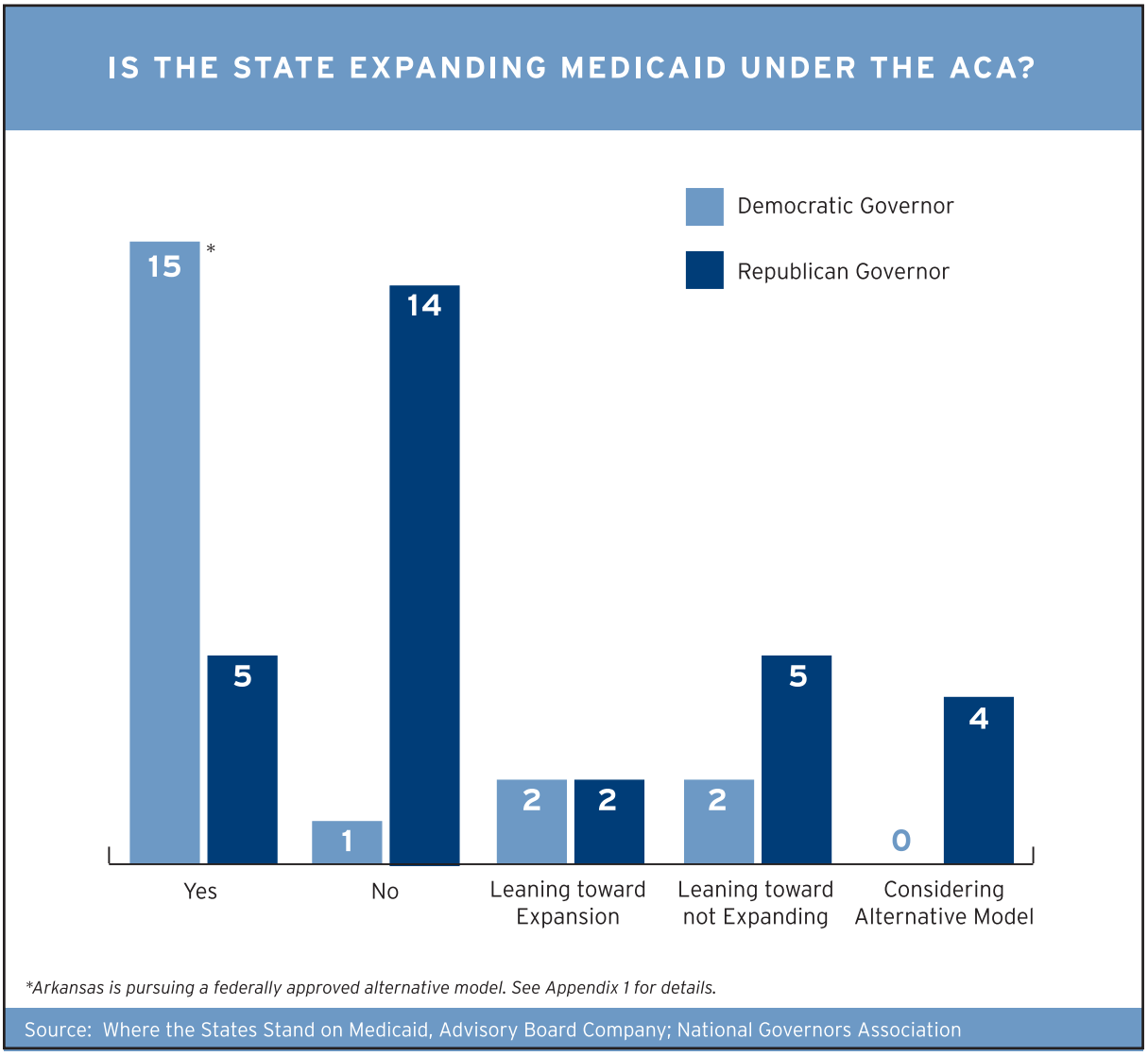


The second key decision that governors had to make regarding implementation of the ACA came as a result of the Supreme Court's decision in *National Federation of Independent Businesses (NFIB) vs. Sebelius*, handed down on June 28, 2012. In deciding the issue, the U.S. Supreme Court determined that because the expansion was a significant change in the Medicaid program – in the words of the Court a change in "kind" not merely "degree" – it constituted a "new program." The Court also noted the size of the expansion in terms of state budgets and the lack of notice given states about Congress's intention to make Medicaid a central element of a comprehensive system of national health reform. For these reasons, the Court held that withholding all Medicaid funding from states that fail to enact the expansion was unconstitutional, though it left the expansion in place as a state option.

Thus governors had to decide whether or not to expand the Medicaid program. As Graph 5 illustrates, this too turns out to have been a partisan decision – with the majority of Democratic governors opting to expand Medicaid and the majority of Republican governors

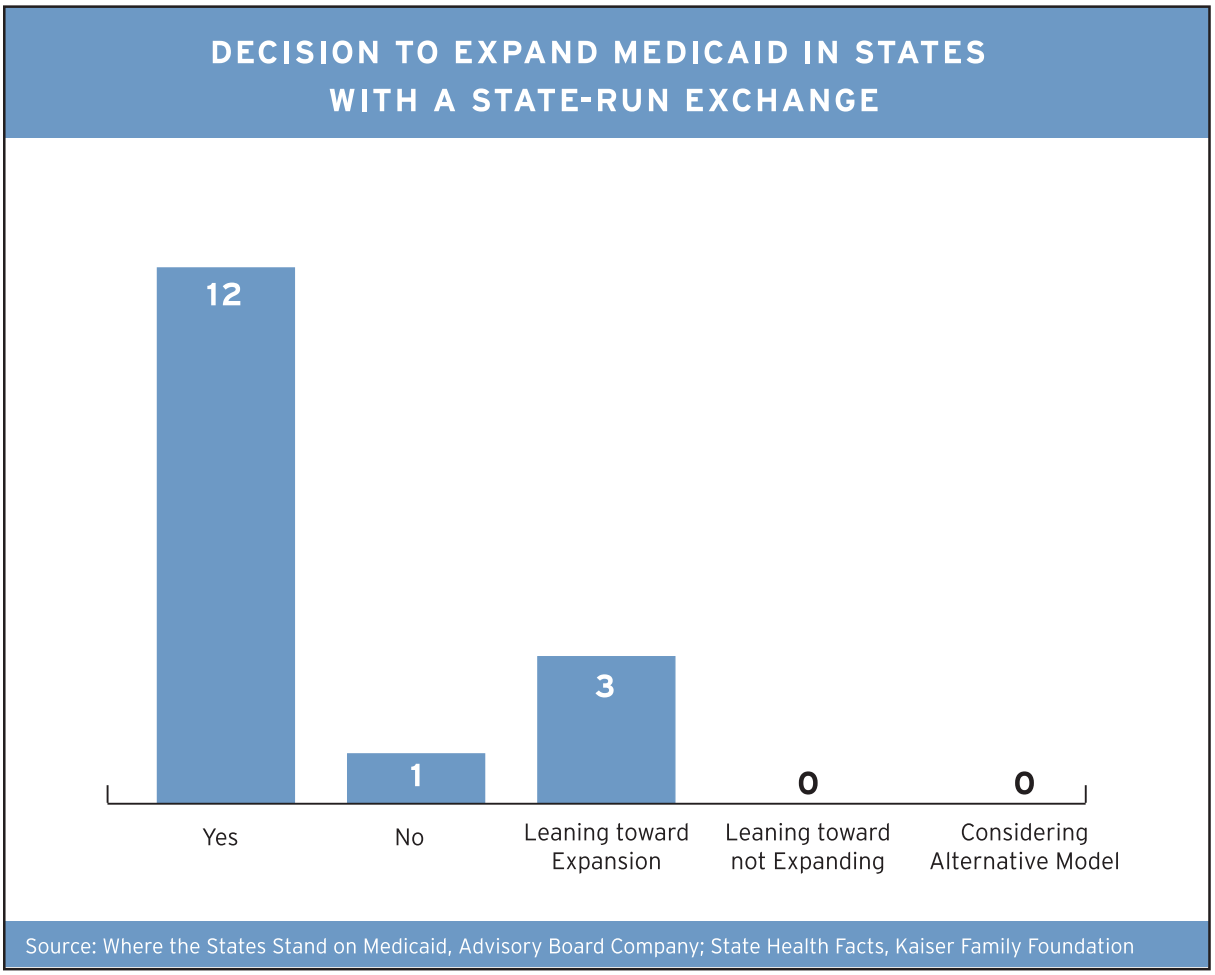
opting not to. However, these decisions were less partisan than the exchange decisions – more Republican governors decided to pursue the Medicaid expansion and there were other Republican governors who would have expanded it but were prevented from doing so by their legislatures. (For a complete listing see Appendix 1)

GRAPH 5



Because Democratic governors tended to opt for state exchanges *and* for the expansion of Medicaid, these states will prove to be the purest test of the thinking behind the ACA since they will do two of the most critical things anticipated to increase coverage. As Graph 6 illustrates, with the exception of Idaho, most of the states that opted to set up exchanges *also* opted to expand Medicaid.

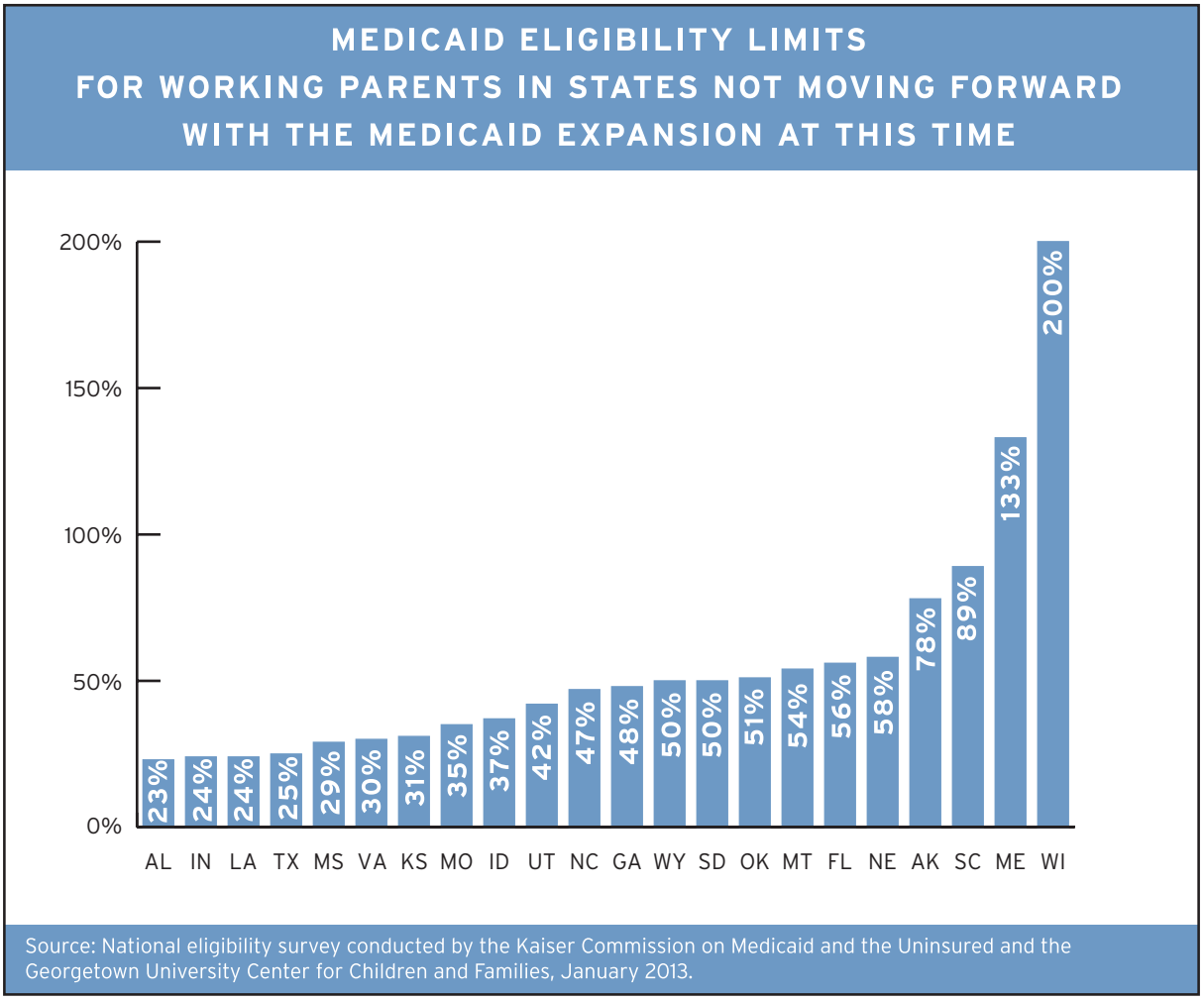
GRAPH 6



Because the law anticipated that all states would expand Medicaid beyond the point where the federal subsidies kicked in (100% of the federal poverty line), the current bill creates a new and unanticipated class of people who may not be able to afford coverage and who are, at the same time, unable to access either Medicaid or the federal subsidy offered through the exchanges. Graph 7 is taken from the Kaiser Commission on Medicaid and the Uninsured. It shows the list of states that have chosen NOT to move forward at this time to expand Medicaid eligibility for working parents. With the sole exceptions of Maine and Wisconsin, which have Medicaid eligibility *at or above* 133% of the federal poverty line already, there will be some proportion of the adult population in each of the states listed below that are not eligible for Medicaid and not eligible for a federal subsidy, therefore, increasing the chances of a significant number of uninsured remaining. The Kaiser Family Foundation has estimated this number to be approximately 6 million who would have been Medicaid eligible.[4]

4 These are individuals with incomes below 100% FPL who are ineligible for Medicaid under the traditional rules (i.e., they are not parents of minor children, pregnant, or people with disabilities). The example might be a 62 year-old woman, whose children are grown, or has no children, and has little income.

GRAPH 7



Source: National eligibility survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, January 2013.

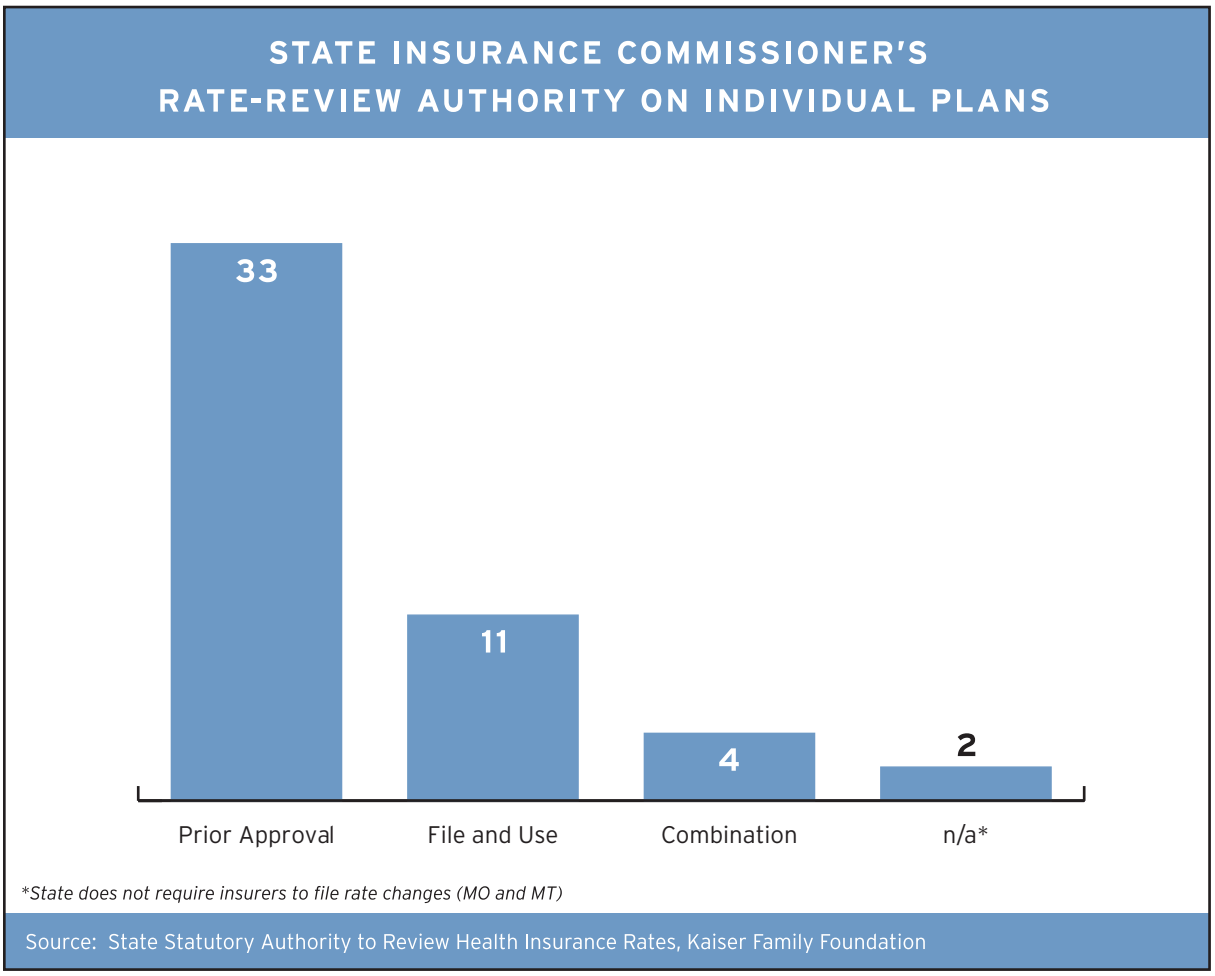
STATE INSURANCE COMMISSIONERS

In addition to the fact that individual governors can decide how to approach or not approach key aspects of the ACA, the second major difference between the ACA and previous large-scale health care legislation is that ACA deals directly with private health insurance plans, the regulation of which, with rare exception, has been left to the states. State health insurance regulatory regimes come in all shapes and sizes, as the following graphs illustrate. (For a full listing of state insurance commissioners see Appendix 2.)

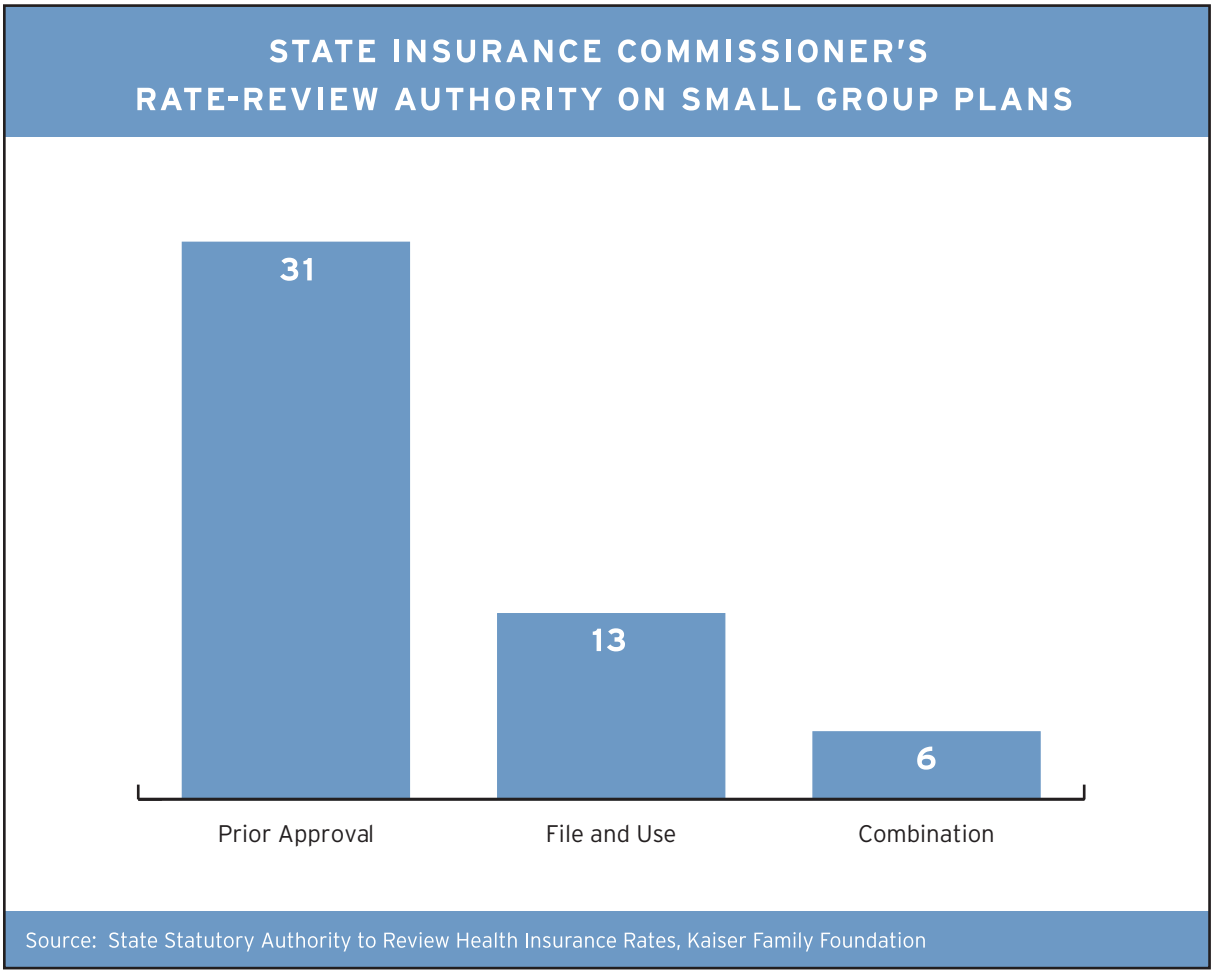
State insurance commissioners have substantial power over the rates that insurance companies are allowed to charge customers. Most of them are appointed by the governor – very few are elected. (See Appendix 2 and 4) (For a full listing of state insurance commissioner's power over rates see Appendix 3) In Graph 8, we see that insurance commissioners have "prior approval" for individual plans in more than half the states in the union – i.e. they must approve the proposed rate an insurer is going to charge for plans before

it is implemented. Likewise, in Graph 9, we see that more than half the states have prior approval authority on small group plans. In "file and use" states – the insurance companies are asked to submit their proposed rates, but approval by the Commissioner is not required before the rates go into effect.

GRAPH 8



GRAPH 9

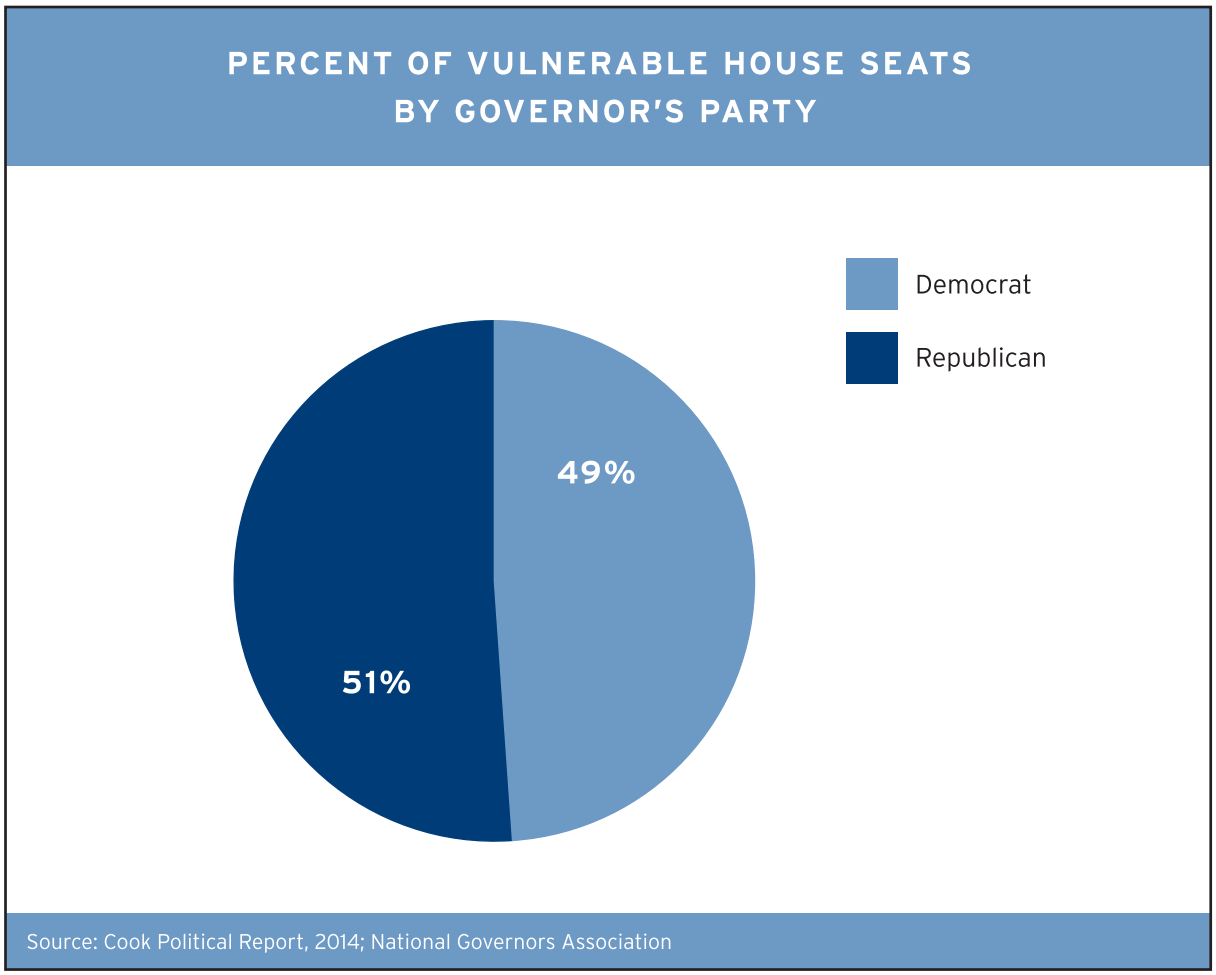


POLITICS AND IMPLEMENTATION: IN THE SHORT-TERM

As we have seen, decisions about the structure of the ACA are heavily influenced by politics. Going forward, politicians on both sides are hoping to use the health care issue to impact the midterm elections of 2014. For Republicans, the hope is that the longstanding skepticism about the law will be reinforced as it is implemented and yield a political bonus in the 2014 midterm elections. Democrats obviously hope that a positive start will help reduce barriers to implementing the law and improve their political prospects.

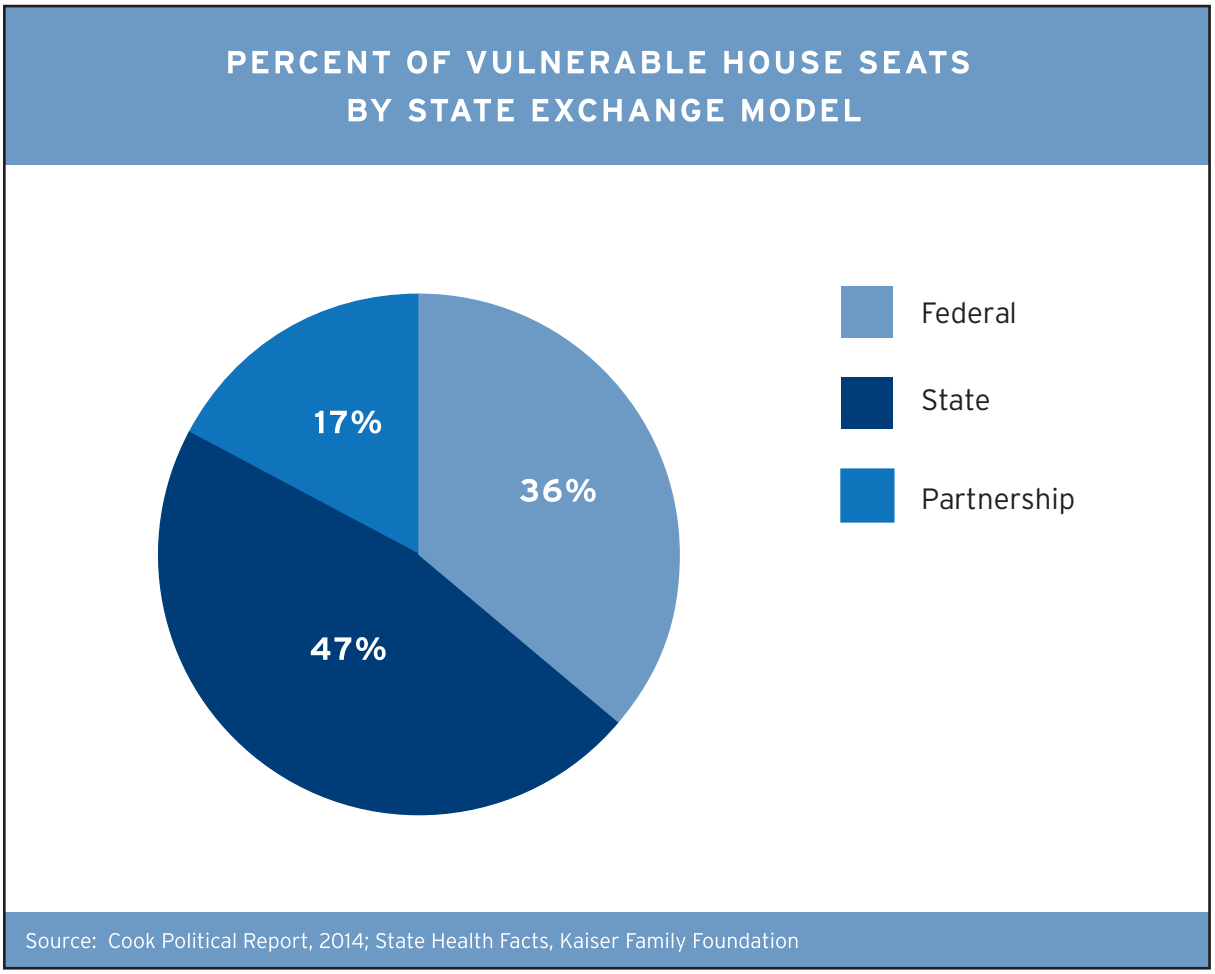
The first thing to say about how this law might impact the midterms is illustrated in Graph 10. The vulnerable House seats in the upcoming midterm elections (as projected by Charlie Cook in the fall of 2013) are almost perfectly evenly divided between states run by Republican governors and states run by Democratic governors.

GRAPH 10



And, as we saw earlier in this paper, most Democratic governors built exchanges and are going to try and make them work; and most Republican governors are letting the federal government do it and, in some instances, placing obstacles in the way in an attempt to protect consumers. (see Graph 11) Thus, vulnerable House seats are almost perfectly evenly divided between states that chose to set up their own exchange and those that didn't.

GRAPH 11



As the political battle moves from Washington to the states, it also moves from theory to implementation with some important differences between those states where the leaders want ACA to work and those that don't. Recently, The *Houston Chronicle* reported that the elected Republican insurance commissioner for the state of Georgia, Ralph Hudgens, told an audience of the Republican faithful that he and the Republican governor were doing "everything in our power to be an obstructionist."[5]

One of the elements of the bill calls for the establishment of navigators in each state. Because the purchase of health insurance is complex to begin with, especially for people who have been uninsured, and because the process of qualifying for a subsidy is complex, the ACA included a provision for "navigators." They are defined as people who would be trained to work, via community and other groups, to help citizens get through the maze of the new health care bill and sign up for insurance. While the states were given startup funds to establish the

5 "Obamacare: Georgia Obstructs Uninsured from Insurance Market," *The Houston Chronicle,* September 13, 2013.

navigators, they are to be funded as part of the marketplace operations — which could be a problem after the first funds run out and states have to find ways to fund the navigators. Although the bill explicitly stated that "navigators" could *not* be insurance issuers — the actual work is similar enough to that done by agents and brokers — some states have been invoking their authority to regulate and license navigators similar to the way they oversee insurance agents and brokers.

In this politically polarized time, some believe these efforts are meant to delay or impede the navigators from achieving their goal of enrolling the eligible. Increasing that perception is the fact that the states that seem to be most concerned about navigators are states controlled by Republicans. Thirteen Republican state attorneys general have raised concerns about inadequate training of navigators and the potential for fraud. Two states, Missouri and Ohio, have gone so far as to "restrict navigators from giving advice about plans and benefits."[6] Florida Governor Rick Scott made news when he decided to ban navigators from operating in health care facilities.[7] And the Republican House Energy and Commerce committee is demanding that community-based organizations in states receiving federal grants for the navigators submit "detailed documentation on training, procedures, monitoring and responsibilities of the navigators."[8]

While there may well be some legitimate efforts to ensure that the quality of the information being provided by the federal navigators is balanced and accurate, that Medicare beneficiaries are not misled into believing they need to buy insurance coverage, and that consumer privacy is protected, in the highly partisan atmosphere in which the ACA is being implemented, state interference with the federal navigators is perceived as simply the latest in a series of steps designed to slow down or impair implementation. Previously in November 2012, Missouri voters approved Proposition E, which would prohibit the Governor from establishing a state-run health insurance exchange. And, as implementation of the ACA moves forward, there will no doubt be other steps taken that could be interpreted as obstructionist. The question is — will any of them matter, given that even in states that are hostile to the ACA implementation, the implementation will still be largely in the hands of the federal government?

HOW WILL WE JUDGE SUCCESS? FOCUSING ON THE LONG-TERM

As implementation unfolds over the coming months and years, there will be a variety of smokescreens thrown up in order to score political points by both sides. The fact that the Republican Congress decided to shut down the government over the ACA means that the political posturing on both sides is likely to be intense. Therefore, it is all the more important

6 Michael Ollove, "Health Insurance navigators draw state scrutiny," *USA TODAY,* September 9, 2013.

7 Jason Millman, "Florida Governor warns against navigators," *Politico*, September 17, 2013.

8 Ibid.

that we identify some clear-cut measures of success or failure. It is also important that we measure success or failure from baselines that will be established in 2014, since our experience with almost every new federal entitlement program is that it takes a few years to get the kinks out and to increase participation.

We don't have to look too far back for examples of joint regulation over quasi-insurance products. Many state regulators remember the issues surrounding the implementation of the Medicare Advantage programs a few years ago when there was joint regulation between The Centers for Medicare and Medicaid Services (CMS) and the state insurance regulators. CMS had primary jurisdiction over the program leaving the state regulators with very limited jurisdiction. Many consumers didn't understand the differences between this program and other insurance programs, so they would call their state insurance department seeking help. In most instances, the state regulator had no jurisdiction and would have to defer to the understaffed CMS offices, which couldn't handle the volume of complaints and requests they were getting. There were even Congressional hearings held in an effort to address and resolve these issues.

In the beginning, there were many problems, including some that bordered on fraud or misrepresentation, but ultimately, by working together, the state and federal regulators were able to address most of these issues to ensure that the public was protected. As of today, the program appears to be operating fairly smoothly, but as noted there was a learning period that did result in confusion between the regulators, consumers, and the companies.

As this example illustrates, it will be important to differentiate between short-term and long-term implementation problems. For instance, there have been computer problems and undoubtedly will be more as the exchanges are opened. In addition, there may well be problems in determining the correct amount of a subsidy a person should get. For a short time at least, some people may get more than they deserve and others less. In fact, the District of Columbia has announced a delay in being able to determine if enrollees are eligible for Medicaid or for government subsidies because of high error rates in the testing phase. Undoubtedly, some unscrupulous people will figure out ways to game the system before the government shuts it down. But these are the sorts of problems that will be worked out. We put them in the category of "short-term" problems because they are expected with an undertaking this large and because the federal government has significant expertise in administering large national subsidy programs.

But a second class of problems stems from more fundamental issues of design. And it is to these that we now turn. There are eight fundamental issues to track as we move forward. These issues are embedded in the design of the Act itself — they cannot be fixed by

technology improvements or by better federal-state coordination. They are fundamental to the architecture of the ACA itself, thus critical to determining success or failure.

Here is our list of things to watch for:

1. **Is there a reduction in the total number of uninsured?**
2. **Is there an increase or stabilization in the cost of premiums on the exchanges and in the private market?**
3. **Are there an adequate number of plans in the exchange and does the number increase or decrease over time? Are plans exiting or entering the market over time?**
4. **Does the number of people who pay the penalty for not having insurance increase or decrease over time?**
5. **Is there a decline in employer coverage?**
6. **Is there a decline in full-time work and an increase in part-time work?**
7. **What is the extent of the conflict between federal and state oversight of health insurance and does it increase or decrease over time?**
8. **Is there evidence of an increase or a decrease in out-of-pocket expenditures on health care?**

1. IS THERE A REDUCTION IN THE TOTAL NUMBER OF UNINSURED?

The overall number of uninsured Americans will be influenced by the number of people who buy insurance on the exchanges, the number of people who get covered by Medicaid, and the number of people who continue to have insurance from their employer. (For a complete list of the number of uninsured by state see Appendix 5.) Many government programs have take-up rates (the number of people who apply for a benefit) that are substantially lower than they would be if everyone who qualified for a benefit actually applied for it. For instance, the take-up rate for unemployment insurance benefits between 1989 and 2011 averaged only 63%. Or another way of looking at this — on average fully 37% of those who qualified for unemployment insurance failed to receive it.[9] Medicaid take-up rates are often far below what would be expected if everyone eligible signed up. Studies have estimated take-up rates as low as 36% and as high as 81% with considerable variation from state to state.[10] Given that most social welfare benefits have problems with take-up rates, prior legislation such as the CHIP legislation (Children's Health Insurance Program) have included provisions (similar to the "navigators" discussed above) so that there is assistance for people who are eligible for the benefit. In spite of this, however, the take-up rate in the first five years of the CHIP program

9 "Unemployment Insurance Take-Up Rates in an Equilibrium Search Model," by Stephane Auray, David L. Fuller and Damba Lkhagvasuren, February 2013. Paper No. 13001, Concordia University, Department of Economics.

10 Ben Sommers, Rick Kronick, Kenneth Finegold, Rosa Po, Karyn Schwartz, and Sherry Glied, "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," *ASPE Issue Brief,* March 2012. Accessed at: http://aspe.hhs.gov/health/reports/2012/medicaidtakeup/ib.shtml

was very low. But more than fifteen years later, the CHIP program has a take-up rate well over three-fourths of eligible children, although there is great variation among states.[11]

Common sense dictates that the more effort a state puts into publicizing the ACA and the more effort it puts into providing assistance to eligible people — the greater the "take-up" rate. Thus, we should expect to see the number of uninsured decrease in states that are promoting their own exchanges at a greater rate than in states that are relying on the federal government. In other words, blue states will probably have bigger decreases in the number of uninsured than red states. However, even in blue states there may be difficulties as the states previously had access to substantial federal grant dollars and money appropriated for administration of the program that will end. At that point the exchanges will be responsible for their operations going forward and recruitment into the program may suffer.

In addition, reduction in the number of uninsured will be affected by the states' decision to expand Medicaid or not. As we saw earlier in this paper, in a large number of states that chose not to expand Medicaid, a new class of the uninsured has been created; ineligible for Medicaid but too poor to qualify for the federal subsidies. This is exactly the sort of problem that, in a less polarized political environment, a package of amendments to the law could have fixed. Despite a series of such problems, the intensity of political opposition to the bill has precluded any such effort.

Thus, in the short run at least, decisions made by red and blue states will most likely result in self-fulfilling prophesies. In blue states, the number of uninsured Americans should decrease more than in red states. In the long run, the amount of increase or decrease in the number of uninsured will also be affected by what happens in the employer-based market — a topic we'll address below.

2. IS THERE A SLOWDOWN OR DECREASE IN THE COST OF PREMIUMS ON THE EXCHANGES AND IN THE PRIVATE MARKET?

A second metric to watch is what happens to premiums. Beginning in 2014, plans offered on the exchanges along with coverage sold to individual and small businesses outside the exchange must meet new regulatory requirements. These new requirements include the coverage of a minimum set of services (essential health benefits). Additionally, all insurers will be prohibited from denying coverage based on preexisting conditions, and there are limits on the extent to which premiums can vary on the basis of age.

11 Ben Sommers, Rick Kronick, Kenneth Finegold, Rosa Po, Karyn Schwartz & Sherry Glied, "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," *ASPE Issue Brief,* March 2012. Accessed at: http://aspe.hhs.gov/health/reports/2012/medicaidtakeup/ib.shtml

Because of these new requirements and the recent imposition of rules on the medical loss ratio, it will be difficult to fairly compare rates for the new exchange products to the current individual market products.[12] But there may well be value in tracking what happens to premiums for products sold in the exchanges and those outside. But here again, nothing is simple.

Under ACA, an insurer can choose to offer individual and small group coverage inside the exchange, outside the exchange, or both. For those insurers who choose to offer coverage both inside and outside of the exchange, all enrollees in all health plans (other than those who have been grandfathered) offered in the individual market, will be considered to be a single risk pool. The same will hold true for small business products. In the case of those issuers who only offer coverage outside the exchange issuers, the risk pool will be based on those groups.

In this area, as well as others where the states are given flexibility, the responses of the states vary. In the case of DC and Vermont, no individual or small group plans are permitted to be sold outside the exchange. In other states, insurers wishing to sell individual and small group coverage outside the exchange must offer them through the exchange as well. And finally, there are states where insurers have freedom to decide where to offer coverage.

Premiums, both inside and outside the exchanges, reflect the issuer's estimates of the cost of covering the group expecting to enroll. In the case of the exchanges, the hope is that given the availability of premium subsidies only to those enrolling through the exchange, the subsidies (which lower the amount these individuals will have to pay for coverage) will entice young healthy individuals into buying coverage.

So what do we know about premiums so far? At this point the news is pretty good. As insurance companies sign up to be part of the exchanges the premiums they are charging have been "generally lower than expected."[13] Most of the ratings areas examined by a Kaiser Family Foundation study show premiums below levels predicted by the Congressional Budget Office.[14] But as is the case in other areas we have described, this varies enormously across the country. For example, Mississippi's premiums are among the highest in the nation, in part because of the lack of competition in many parts of the state. Tennessee has premiums among the lowest.

However, while the first year of premiums might be attractive enough to induce many people to sign up, the question is what happens if the whole system falls prey to what has become known as "adverse selection." Adverse selection refers to the possibility that sick people

12 Medical Loss Ratio refers to the requirement that insurers spend a certain percentage of the premium dollars on services versus administration.

13 Cynthia Cox, Gary Claxton, Larry Levitt, Hana Khosla, "An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014," The Kaiser Family Foundation, September, 2013.

14 Ibid.

with years of unmet health care needs will sign up for insurance on the new exchanges while healthy (often younger) people will choose to pay the relatively small penalty versus paying what may be a higher cost premium. If, in the early years of the ACA, sick people buy health insurance while healthy people opt out, costs to insurance companies and to the insured will rise.

If, in fact, adverse selection occurs, or the adjustments are inadequate, there will be a great deal of pressure on state insurance regulators and the federal government to allow premium costs to increase. While the ACA includes provisions establishing a risk adjustment program and a re-insurance program to help address these issues — the ability to fully recognize these risks is one of the great unknowns as implementation begins. Increases in costs will put pressure on the government to increase the level of premium support paid to eligible citizens. Fear of adverse selection looms large in the minds of those who conclude that the ACA, while effective as a subsidy program, is weak as a cost-control program. The possibility of out-of-control costs to government plays into the hands of opponents of the bill.

3. ARE THERE AN ADEQUATE NUMBER OF PLANS IN THE EXCHANGE AND DOES THE NUMBER INCREASE OR DECREASE OVER TIME?

A second outcome of adverse selection could be that insurance companies decide, over time, that the risk to them of participating in the exchanges is simply not worth it — leading them to choose not to participate or drop out of the exchanges. For a current example of this trend in the insurance markets, you only need to look at the issues many states are now seeing in their coastal property insurance markets. In some cases, the risk is too great for the carrier and they are leaving the markets. In others, premiums are too high for the consumer.[15] Thus, a third measure to watch is whether the number of plans present on the exchanges increases or decreases over time.

Implicit in the architecture of the bill is the assumption that insurance companies will see the ACA and its subsidies as a potential source of new business and will want to participate. But if, as some critics are predicting, the reinsurance and risk adjustments are not adequate, if adverse selection occurs — *and persists* — insurance companies may decide that participation is not a good deal for them after all. If adverse selection occurs and state governments respond to rising costs by trying to limit premium increases and the federal government responds to rising costs by limiting subsidies, then a certain number of insurers may decide to drop out of participation in the exchanges — thus severely limiting choice and competition.

15 Terrell Johnson, "Skyrocketing Flood Insurance Rates Bring Financial Chaos, Heartache to Coastal Homeowners Across U.S.," *The Weather Channel,* September 28, 2013. Accessed at: http://www.weather.com/news/science/environment/new-flood-insurance-rules-bring-chaos-heartache-coastal-homeowners-20130927

4. DOES THE NUMBER OF PEOPLE WHO PAY THE PENALTY FOR NOT HAVING INSURANCE INCREASE OR DECREASE OVER TIME?

Contributing to worries about adverse selection is the fear that the penalties for not purchasing health insurance are too low to incentivize healthy people to buy insurance. The IRS will administer the "individual shared responsibility provision" of the ACA. While there are a series of exemptions to this provision – most Americans who file tax returns will have to attest to the fact that they have "minimum essential coverage" as defined by the regulations.[16] If an individual or family member does not have "minimum essential coverage," they need to pay a fine to the IRS.

Two provisions of the bill could contribute to adverse selection. First of all, the fines are low: $95 per person or 1% of income in 2014; increasing to $325 or 2% of income in 2015 and up to $695 or 2.5% of income in 2016. After that, the fines are increased annually by the cost of living adjustment. Great uncertainty surrounds how these fines will play out. At first glance, it seems that the fines are way too low to incentivize healthy people with low incomes to buy insurance. After all, a single person living in Baltimore, earning $28,725 a year can expect to pay $146 per month or $1752 a year for health care coverage under the cheapest "bronze" plan.[17] A healthy person might conclude that paying the fine of $287 is a better use of their money.

However, this same person would be eligible for a subsidy and the subsidy would take the annual cost of that bronze plan down to $1332 per year. At this point the cost of health insurance (minus the fine) is just over $1000 and the individual's calculation could change. If the premiums on the exchange don't rise and if the government subsidy remains about where it is today, by 2016, this person might conclude that the purchase of health care makes economic sense. Most likely, it will take some time for people to figure out these calculations for themselves and thus no one can say at this point whether the penalties will add to the chances of adverse selection or decrease them. There is also the issue of perceived value of health insurance. While insurance will undoubtedly cost more than paying the penalty, if people perceive the coverage to be valuable they will be more likely to purchase coverage than go bare, even if it costs more.

Second, the consequences for not paying this penalty are not as severe as the consequences for getting cross-wise with the IRS on other issues. For instance, Section 1501 of the ACA reads that a taxpayer who fails to pay a penalty "shall not be subject to any criminal prosecution or penalty with respect to such failure." It will not make the taxpayer subject to liens or levies. On the other hand, the penalties would accrue interest and would carry over from year to year.

16 For example: religion, being a member of an Indian tribe or being below the threshold that requires filing a tax return keeps someone from having to pay the fine.

17 Cynthia Cox, Gary Claxton, Larry Levitt, Hana Khosla, "An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014" Ibid.

However, the absence of serious sanctions might make some people conclude that it's okay to not buy health insurance *and* not pay the penalty.

Thus, if the incentive structure in the ACA is strong enough, the number of people who pay the fine should decrease over time. If the incentive structure is weak, as many supporters as well as critics of the bill suspect, then the number of people paying the fine might increase – an indicator, perhaps, that adverse selection is going on.

5. IS THERE A DECLINE IN EMPLOYER COVERAGE?

A significant decline in the number of people with employer-sponsored coverage would be a blow to the success of the ACA. After all, the commitment made to the American people by the president is that the bill that would not affect the coverage enjoyed by most Americans who already have health insurance through their employers. And the bill includes a penalty for employers of 50 or more who do not offer health insurance – although that provision has been delayed until 2015. A recent study in *Health Affairs* by Thomas Buchmueller and Colleen Carey, concludes that the decline in employer-sponsored health insurance as a result of the ACA is likely to be relatively small. Measuring this is complicated by the fact that employer-sponsored insurance (ESI) has been declining for more than a decade – so care will need to be taken to distinguish the effects of the ACA from those pressures already in place. However, if the rate of decline increases, it could be a sign that the ACA is to blame.

Employers, like individuals, could conclude that it makes economic sense to pay the penalty. This could be trouble on two fronts. First, it would increase the number of people moving to the exchanges or to Medicaid and thus increase the cost of the program to the government. And, secondly, if employers drop health insurance because their workers are sicker than others this could further add to the pool of sick people in the exchanges and add to the problem of adverse selection.[18]

6. IS THERE A DECLINE IN FULL-TIME WORK AND AN INCREASE IN PART-TIME WORK?

The ACA mandates that any employer (with 50 or more employees) paying "full-time workers" (defined as 30 hours per week) must provide health insurance or face a fine. Although

18 See for example, Alex Nussbaum, "Trader Joe's Sends Part-Timers to Obama Health Exchanges" in Bloomberg, September 13, 2013. Accessed at: http://www.bloomberg.com/news/2013-09-12/trader-joe-s-sends-part-timers-to-obama-health-exchanges.html; Bruce Japsen, "Walgreen Joins The Rush To Employer Exchanges" in Forbes, September 17, 2013. Accessed at: http://www.forbes.com/sites/brucejapsen/2013/09/17/walgreen-joins-rush-to-employer-exchanges-an-alternative-to-obamacare-marketplace/
Christ Burritt, "Home Depot Sending 20,000 Part-Timers to Health Exchanges" in Bloomberg, September 19, 2013. Accessed at: http://www.bloomberg.com/news/2013-09-19/home-depot-sending-20-000-part-timers-to-health-exchanges.html

the employer mandate has been delayed for a year, as implementation draws near this requirement will continue to be the focus of a great deal of attention, especially by opponents of the bill who have argued that employers are pulling back the hours they offer people in order to save on health care costs. This could be a very serious problem in an economy that still has not replaced the jobs lost during the Great Recession. Fueling this critique is a study by Christopher J. Conover and Jed Graham from the American Enterprise Institute, who argue that, in the first half of 2013, 4.3 part-time jobs were created for every full-time job. Critics argue that the number of jobs being created is so small that this distorts comparisons to earlier eras.[19] And the White House maintains that there is no evidence that this is happening.

Nonetheless, adding to the concern that the ACA will cause a decrease in the hours per week worked by Americans is anecdotal evidence that in some places employers are reducing the workweek in order to evade the requirements of the law and save money. For instance, it has been reported that some strapped local governments and some school districts around the country have been cutting the hours of employees to less than thirty hours per week in order to save on health care costs. Senator Susan Collins (R-ME) contends that she knows of a school district in Maine that is planning to "track and cap the number of hours that substitute teachers can work to ensure that they don't work more than 29 hours a week." Senator Collins has introduced legislation that would modify the federal definition of full time employee from 30 hours to 40 hours per week.[20]

It may take some time to figure out whether the law is having an effect on the number of hours worked or not and the causality will, no doubt, occupy academics for years to come. But if, after a year or two there appears to be some across the board reduction in hours and there are no other explanations, the ACA will be suspect and a population hungry for job creation will not be happy.

7. WHAT IS THE EXTENT OF THE CONFLICT BETWEEN FEDERAL AND STATE OVERSIGHT OF HEALTH INSURANCE AND DOES IT INCREASE OR DECREASE OVER TIME?

As we indicated at the beginning of this paper, the ACA is very much a project of both state and federal government. The states' historic role in regulating the insurance industry, including the health insurance industry, sets up the potential for clashes even in those states that are not, by virtue of their partisan make-up, hostile to the ACA. We saw earlier in this paper that the issue of regulating the "navigators" is already creating conflict between states and the federal government. And we can anticipate other areas of conflict.

19 Evan Soltas, "Is Obamacare Forcing you to work part-time?" in Bloomberg, August 8, 2013. Accessed at: http://www.bloomberg.com/news/2013-08-08/is-obamacare-forcing-you-to-work-part-time-.html

20 "Senator Collins Pushes for change in Obamacare," CNN Political Unit, August 3, 2013. Accessed at: http://politicalticker.blogs.cnn.com/2013/08/03/sen-collins-pushes-for-change-in-obamacare

For instance, who will deal with consumer complaints regarding exchanges and the adequacy of provider networks? We are already hearing concerns from public hospitals and other providers that they are being excluded from the plans networks sell on the exchange – notwithstanding the fact that they have cared for many of the uninsured in the past. Is this a problem for The Center for Consumer Information & Insurance Oversight (CCIIO) at the Department of Health and Human Services? What about CMS or HHS? Or state insurance commissioners?

Who will review each states process to ensure compliance with federal law? Are any states doing this themselves? What about multi-state national plans? How will they work? They will have to be sold in all 50 states. Will state law be preempted by the feds if it conflicts with ACA? How will state commissioners deal with insurance companies that are non-compliant under the law? Will they refuse licenses?

How markets change, and what happens to prices and competition, will depend on a confluence of factors including decisions by the states, employers, insurance companies, and the federal government.

These conflicts are to be expected in the first year or two of implementation. But if they do not diminish over time, if they result in complex court cases, and if the conflict interferes with the operation of the system, then the law itself will come in for blame.

8. IS THERE EVIDENCE OF AN INCREASE OR A DECREASE IN OUT-OF-POCKET EXPENDITURES ON HEALTH CARE?

Today, many people are facing rising out-of-pocket costs because employers and insurers are altering the current deductible and co-insurance requirements as a method of reducing their costs and shifting more costs to consumers. Deductibles are getting higher, and while many employer plans have out-of-pocket limits in place, any out-of-pocket limits in individual plans are traditionally very high if they exist at all. One of the goals of the ACA was to make coverage more affordable, which includes out-of-pocket costs, not just premiums, hence cost-sharing subsidies, which will reduce costs for some. Despite these goals, the deductibles for bronze and even silver plans in the exchanges are higher than those found in a number of plans today. How consumers perceive these costs, whether they are considered to be reasonable or unaffordable, will also influence their decisions to enroll, and ultimately, the success or failure of the law.

CONCLUSION

The United States is at the opening stages of one of the largest changes to the health care sector of the economy in half a century. The law was intended to fix a wide variety of problems in the health insurance market and, in so doing, result in a better market for everyone — not just the uninsured. But along the way, the law became one of the most highly politicized pieces of legislation in modern history, and the politicization of the law extends well into the implementation phase. As we have illustrated, state choices reflect, by and large, the partisan make-up of the states. There are some states taking actions that could be seen as obstructing the implementation of the law. On the other hand, even some of the law's supporters worry that the architecture of the Act and the incentive structures in it could result in adverse selection — an outcome that could affect many of the measures of success or failure discussed in this paper.

The highly politicized environment in which this law takes place means that people will see what they want to see. What we have hoped to do in this paper is to move beyond the intense partisanship that surrounds the initial stages of implementation. We hope we have offered a balanced way of looking at the ACA that takes us beyond today's political situation and outlines some meaningful metrics for establishing success or failure (or both) in the years to come.

APPENDIX 1

STATE	GOVERNOR	GOVERNOR'S PARTY	IS THE GOVERNOR UP FOR REELECTION?	HEALTH INSURANCE EXCHANGE MODEL	IS THE STATE EXPANDING MEDICAID?
Alabama	Robert Bentley	Republican	Yes	Federal	No
Alaska	Sean Parnell	Republican	Yes	Federal	No
Arizona	Jan Brewer	Republican	No	Federal	Yes
Arkansas	Mike Beebe	Democrat	No	Partnership	Alternative Expansion Model §
California	Jerry Brown	Democrat	Yes	State	Yes
Colorado	John Hickenlooper	Democrat	Yes	State	Yes
Connecticut	Dan Malloy	Democrat	Yes	State	Yes
Delaware	Jack Markell	Democrat	No	Partnership	Yes
Florida	Rick Scott	Republican	Yes	Federal	Leaning Toward Not Expanding
Georgia	Nathan Deal	Republican	Yes	Federal	No
Hawaii	Neil Abercrombie	Democrat	Yes	State	Leaning Toward Expansion
Idaho	C.L. "Butch" Otter	Republican	Yes	State	No
Illinois	Pat Quinn	Democrat	Yes	Partnership	Yes
Indiana	Mike Pence	Republican	No	Federal	Considering Alternative Model
Iowa	Terry Branstad	Republican	Yes	Partnership	Considering Alternative Model
Kansas	Sam Brownback	Republican	Yes	Federal*	No
Kentucky	Steven Beshear	Democrat	No	State	Leaning Toward Expansion
Louisiana	Bobby Jindal	Republican	No	Federal	No
Maine	Paul LePage	Republican	Yes	Federal*	No
Maryland	Martin O'Malley	Democrat	No	State	Yes
Massachusetts	Deval Patrick	Democrat	No	State	Yes
Michigan	Rick Snyder	Republican	Yes	Partnership	Yes
Minnesota	Mark Dayton	Democrat	Yes	State	Yes
Mississippi	Phil Bryant	Republican	No	Federal	No
Missouri	Jay Nixon	Democrat	No	Federal	Leaning Toward Not Expanding
Montana	Steve Bullock	Democrat	No	Federal*	No
Nebraska	Dave Heineman	Republican	No	Federal*	No
Nevada	Brian Sandoval	Republican	Yes	State	Leaning Toward Expansion
New Hampshire	Maggie Hassan	Democrat	Yes	Partnership	Leaning Toward Not Expanding
New Jersey	Chris Christie	Republican	No+	Federal	Yes

STATE	GOVERNOR	GOVERNOR'S PARTY	IS THE GOVERNOR UP FOR REELECTION?	HEALTH INSURANCE EXCHANGE MODEL	IS THE STATE EXPANDING MEDICAID?
New Mexico	Susana Martinez	Republican	Yes	State	Yes
New York	Andrew Cuomo	Democrat	Yes	State	Yes
North Carolina	Pat McCrory	Republican	No	Federal	No
North Dakota	Jack Dalrymple	Republican	No	Federal	Yes
Ohio	John Kasich	Republican	Yes	Federal*	Leaning Toward Expansion
Oklahoma	Mary Fallin	Republican	Yes	Federal	Considering Alternative Model
Oregon	John Kitzhaber	Democrat	Yes	State	Yes
Pennsylvania	Tom Corbett	Republican	Yes	Federal	Considering Alternative Model
Rhode Island	Lincoln Chafee	Democrat	Yes	State	Yes
South Carolina	Nikki Haley	Republican	Yes	Federal	No
South Dakota	Dennis Daugaard	Republican	Yes	Federal*	Leaning Toward Not Expanding
Tennessee	Bill Haslam	Republican	Yes	Federal	Leaning Toward Not Expanding
Texas	Rick Perry	Republican	Yes	Federal	No
Utah	Gary Herbert	Republican	No	Other†	Leaning Toward Not Expanding
Vermont	Peter Shumlin	Democrat	Yes	State	Yes
Virginia	Bob McDonnell	Republican	No+	Federal*	Leaning Toward Not Expanding
Washington	Jay Inslee	Democrat	No	State	Yes
West Virginia	Earl Ray Tomblin	Democrat	No	Partnership	Yes
Wisconsin	Scott Walker	Republican	Yes	Federal	No
Wyoming	Matthew Mead	Republican	Yes	Federal	No

* State will take on additional plan management functions to support certification of qualified health plans in the federally-facilitated exchange under a "Marketplace Plan Management" model

† State will run small business (SHOP) exchange with a federally facilitated individual exchange

‡ Jan Brewer is term-limited, but is appealing to overturn the term limits and run for reelection

+ Chris Christie and Bob McDonnell (not running) are up for reelection in November 2013

§ Under the Arkansas alternative expansion plan, the state will accept money for Medicaid expansion under the ACA, but will use it to buy private insurance for about 250,000 eligible low-income residents. The plan was federally approved in February 2013.

APPENDIX 2

STATE	IS THE COMMISSIONER ELECTED OR APPOINTED?	COMMISSIONER'S PARTY*	GOVERNOR'S PARTY
Alabama	Appointed	Non-partisan	Republican
Alaska	Appointed	Non-partisan	Republican
Arizona	Appointed	Non-partisan	Republican
Arkansas	Appointed	Non-partisan	Democrat
California	Elected	Democrat	Democrat
Colorado	Appointed	Non-partisan	Democrat
Connecticut	Appointed	Non-partisan	Democrat
Delaware	Elected	Democrat	Democrat
Florida	Appointed	Non-partisan	Republican
Georgia	Elected	Republican	Republican
Hawaii	Appointed	Non-partisan	Democrat
Idaho	Appointed	Non-partisan	Republican
Illinois	Appointed	Non-partisan	Democrat
Indiana	Appointed	Non-partisan	Republican
Iowa	Appointed	Non-partisan	Republican
Kansas	Elected	Republican	Republican
Kentucky	Appointed	Non-partisan	Democrat
Louisiana	Elected	Republican	Republican
Maine	Appointed	Non-partisan	Republican
Maryland	Appointed	Non-partisan	Democrat
Massachusetts	Appointed	Non-partisan	Democrat
Michigan	Appointed	Non-partisan	Republican
Minnesota	Appointed	Non-partisan	Democrat
Mississippi	Elected	Republican	Republican
Missouri	Appointed	Non-partisan	Democrat
Montana	Elected	Democrat	Democrat
Nebraska	Appointed	Non-partisan	Republican
Nevada	Appointed	Non-partisan	Republican
New Hampshire	Appointed	Non-partisan	Democrat
New Jersey	Appointed	Non-partisan	Republican
New Mexico	Appointed	Non-partisan	Republican
New York	Appointed	Non-partisan	Democrat
North Carolina	Elected	Democrat	Republican
North Dakota	Elected	Republican	Republican
Ohio	Appointed	Republican	Republican
Oklahoma	Elected	Republican	Republican

STATE	IS THE COMMISSIONER ELECTED OR APPOINTED?	COMMISSIONER'S PARTY*	GOVERNOR'S PARTY
Oregon	Appointed	Non-partisan	Democrat
Pennsylvania	Appointed	Non-partisan	Republican
Rhode Island	Appointed	Non-partisan	Democrat
South Carolina	Appointed	Non-partisan	Republican
South Dakota	Appointed	Non-partisan	Republican
Tennessee	Appointed	Non-partisan	Republican
Texas	Appointed	Non-partisan	Republican
Utah	Appointed	Non-partisan	Republican
Vermont	Appointed	Non-partisan	Democrat
Virginia	Appointed	Non-partisan	Republican
Washington	Elected	Democrat	Democrat
West Virginia	Appointed	Non-partisan	Democrat
Wisconsin	Appointed	Non-partisan	Republican
Wyoming	Appointed	Non-partisan	Republican

*Commissioner's Party reflects the official party alignment as listed on the commissioner's website.

APPENDIX 3

STATE	INSURANCE COMMISSIONER'S AUTHORITY - INDIVIDUAL PLANS	INSURANCE COMMISSIONER'S AUTHORITY - SMALL GROUP PLANS	HEALTH INSURANCE EXCHANGE MODEL
Alabama	Combination	Combination	Federal
Alaska	Prior Approval	Prior Approval	Federal
Arizona	File and Use	File and Use	Federal
Arkansas	Prior Approval	Prior Approval	Partnership
California	File and Use	File and Use	State
Colorado	Combination	Combination	State
Connecticut	Prior Approval	Prior Approval	State
Delaware	Prior Approval	Prior Approval	Partnership
Florida	Prior Approval	Prior Approval	Federal
Georgia	Combination	Prior Approval	Federal
Hawaii	Prior Approval	Prior Approval	State
Idaho	File and Use	File and Use	State
Illinois	File and Use	File and Use	Partnership
Indiana	Prior Approval	Prior Approval	Federal
Iowa	Prior Approval	Prior Approval	Partnership
Kansas	Prior Approval	Prior Approval	Federal*
Kentucky	Prior Approval	Prior Approval	State
Louisiana	File and Use	File and Use	Federal
Maine	File and Use	Combination	Federal*
Maryland	Prior Approval	Prior Approval	State
Massachusetts	Prior Approval	Prior Approval	State
Michigan	Prior Approval	Prior Approval	Partnership
Minnesota	Prior Approval	Prior Approval	State
Mississippi	Prior Approval	Prior Approval	Federal
Missouri	n/a ‡	File and Use	Federal
Montana	n/a ‡	File and Use	Federal*
Nebraska	Prior Approval	Prior Approval	Federal*
Nevada	Prior Approval	Prior Approval	State
New Hampshire	Prior Approval	Prior Approval	Partnership
New Jersey	File and Use	File and Use	Federal
New Mexico	Prior Approval	Prior Approval	State
New York	Prior Approval	Prior Approval	State
North Carolina	Prior Approval	Prior Approval	Federal
North Dakota	Prior Approval	Prior Approval	Federal
Ohio	Prior Approval	Prior Approval	Federal*
Oklahoma	File and Use	Prior Approval	Federal

STATE	INSURANCE COMMISSIONER'S AUTHORITY - INDIVIDUAL PLANS	INSURANCE COMMISSIONER'S AUTHORITY - SMALL GROUP PLANS	HEALTH INSURANCE EXCHANGE MODEL
Oregon	Prior Approval	Prior Approval	State
Pennsylvania	Prior Approval	Combination	Federal
Rhode Island	Prior Approval	Prior Approval	State
South Carolina	Prior Approval	File and Use	Federal
South Dakota	Prior Approval	Prior Approval	Federal*
Tennessee	Prior Approval	Prior Approval	Federal
Texas	File and Use	File and Use	Federal
Utah	File and Use	File and Use	Other†
Vermont	Prior Approval	Prior Approval	State
Virginia	Prior Approval	File and Use	Federal*
Washington	Prior Approval	Combination	State
West Virginia	Prior Approval	Prior Approval	Partnership
Wisconsin	File and Use	File and Use	Federal
Wyoming	Combination	Combination	Federal

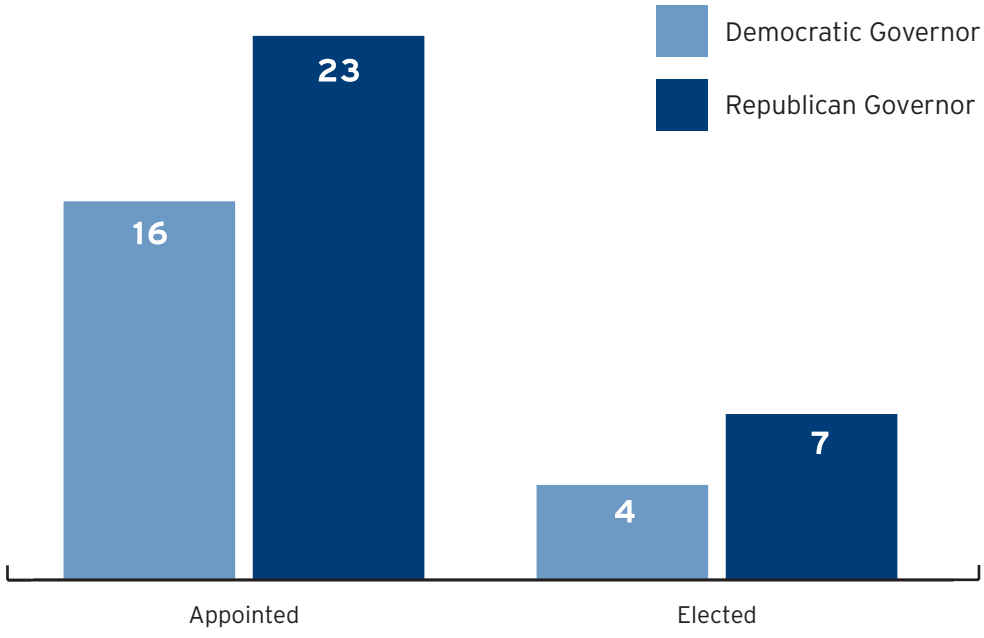
* State will take on additional plan management functions to support certification of qualified health plans in the federally-facilitated exchange under a "Marketplace Plan Management" model

† State will run small business (SHOP) exchange with a federally facilitated individual exchange

‡ State does not require insurers to file new and proposed rate changes with the department of insurance

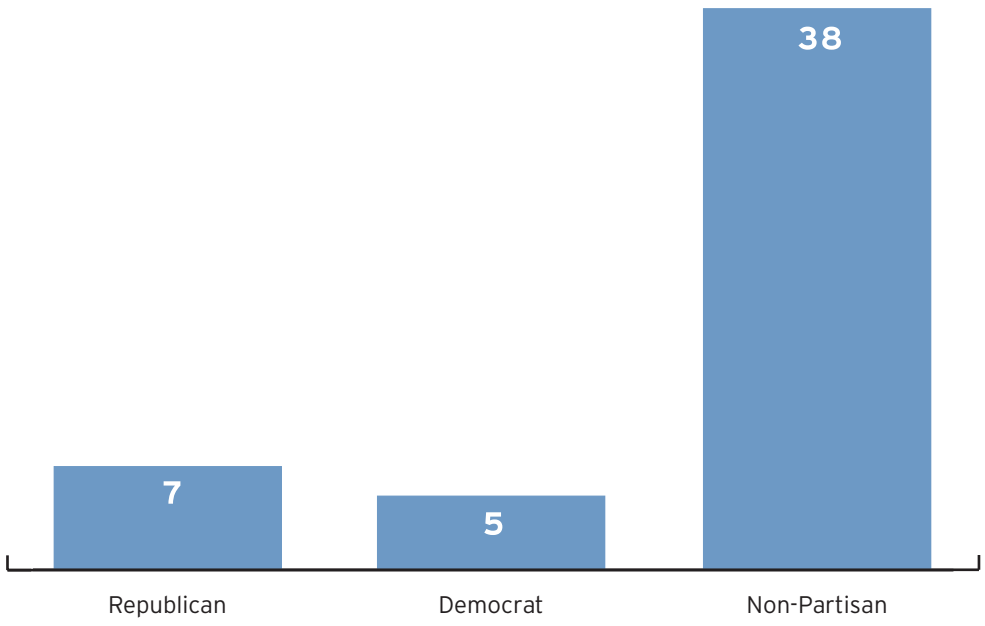
APPENDIX 4

IS THE STATE INSURANCE COMMISSIONER ELECTED OR APPOINTED?



Source: National Association of Insurance Commissioners; National Governors Association

OFFICIAL PARTY OF THE STATE INSURANCE COMMISSIONER*



**Official party reflects the party alignment as listed on the commissioner's website*

Source: National Association of Insurance Commissioners

APPENDIX 5

STATE	UNINSURED POPULATION
Alabama	14%
Alaska	18%
Arizona	18%
Arkansas	18%
California	20%
Colorado	14%
Connecticut	10%
Delaware	11%
Florida	20%
Georgia	20%
Hawaii	8%
Idaho	18%
Illinois	15%
Indiana	13%
Iowa	11%
Kansas	13%
Kentucky	15%
Louisiana	20%
Maine	10%
Maryland	13%
Massachusetts	4%
Michigan	13%
Minnesota	9%
Mississippi	19%
Missouri	14%
Montana	18%
Nebraska	13%
Nevada	22%
New Hampshire	11%
New Jersey	16%
New Mexico	21%
New York	14%
North Carolina	17%
North Dakota	11%
Ohio	14%
Oklahoma	17%
Oregon	15%
Pennsylvania	11%
Rhode Island	12%
South Carolina	20%
South Dakota	13%
Tennessee	14%
Texas	24%
Utah	14%
Vermont	9%
Virginia	14%
Washington	14%
West Virginia	14%
Wisconsin	10%
Wyoming	18%

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