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Chapter 3: Policy and Politics: The Process of Implementation

The passage of the Patient Protection and Affordable Care Act (ACA) raised a broad range of policy issues for states to consider. While those policy questions are important (and are the subject of much of the *2011 State of the States*), states also spent time thinking about the *process* through which they would gather information and make decisions. They asked questions such as: Which state staff should be involved in major decisions? How public should the decision-making process be? Should we establish formal committees or task forces? Each state answered those questions in their own way, but they also learned from each other, particularly as they watched the information being developed in states that decided to have a more public process.

Decisions about process were impacted by the political landscape in the state. Many states had elections for governor in 2010, so many incumbent governors were uncertain whether they would be around to implement the decisions being made. For states where this uncertainty existed, there was even more impetus to involve outside stakeholders in the process, because those groups would outlast the term of the sitting governor. Some states moved quickly because a governor wanted to run on the issue of health care, while other governors shied away from the issue during their campaign.

The ACA gave states a central role in the implementation of health reform. The capacity and commitment to implementation within states was influenced by diverse factors, including their political environment, policy process, and the goals of their political leaders. Accordingly, state policymakers are reacting to the law's various components in different ways.

POLITICAL ENVIRONMENT

For the majority of states, 2010 was a year of significant political uncertainty and turnover. Thirty-seven gubernatorial races and numerous legislative races were determined in November. In a number of states, the campaign process slowed reform efforts throughout the summer and fall and dramatic changes in political leadership on election day added uncertainty to future efforts.

Prior to the election, 24 states had Republican governors, 26 were led by Democratic governors. Post-election, 29 states have Republican governors, 20 have Democratic governors, and one state has an independent.[1] Five states moved from Republican governors to Democratic governors: California, Connecticut, Hawaii, Minnesota, and Vermont. Rhode Island's outgoing Republican governor will be replaced by an Independent governor. Eleven states transitioned from Democratic to Republican governors: Iowa, Kansas, Maine, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, Tennessee, Wisconsin, and Wyoming.[2]

Republicans picked up more than 675 legislative seats across the country, resulting in 11 states gaining Republican majorities in both houses: Alabama, Indiana, Maine, Michigan, Minnesota, Montana, New Hampshire, North Carolina, Ohio, Pennsylvania, and Wisconsin. Four states now have newly divided legislatures: Colorado, Iowa, Louisiana, and New York. Republicans will control both houses in 25 states, up from 14 before the election. The Oregon House of Representatives is evenly split with each party having 30 members.[3]

Table 1: **States with Legislation Related to ACA Compliance and/or Enforcement.**[4]

State	Legislation (2010)	Description
California	Senate Bill 900/Assembly Bill 1602	Enacts the California Patient Protection and Affordable Care Act to implement reforms under the federal ACA and establishes a health insurance exchange as an independent entity in California.
Maryland	Senate Bill 57	Gives the state authority to enforce the insurance market provisions of the ACA.
Massachusetts	Senate Bill 2585	Establishes a small group wellness incentive program and requires the commissioner of insurance to apply for and accept all available federal funding in the ACA.
New Hampshire	Senate Bill 455	Allows the insurance commissioner to implement insurance reforms and revise dependent coverage to comply with the ACA.
North Carolina	Senate Bill 897	Creates and allows a subdivision of the Department of Insurance to administer and enforce the provisions of the ACA to the extent that provisions apply to persons subject to the Insurance Commissioner's jurisdiction.

As of December 2010, the impact of these results on implementation of the ACA is still unclear. Several states, such as Iowa, Maine, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, and Wisconsin, had out-going governors that were very supportive of the ACA, and governors-elect who are more critical of the law.

The implications of the elections will go beyond a change in party leadership, or legislative majority. In many states, experienced staff—in the governor's office, in gubernatorial appointee positions, and in the legislature—will likely resign or be replaced. The loss of their health care expertise and facility with the political and policy processes of their state will impact the speed with which the new administrations and legislatures can address the complex issues surrounding health reform implementation.

POLICY PROCESS

In 2010, in response to the passage of the ACA, many states created task forces or councils focused on health reform. **Tables 1** and **2** show official state actions on health reform during the past year. **Table 1** shows the states that have taken legislative action on reform, typically by creating authority within the states to implement sections of ACA such as exchanges and insurance premium rate review. As **Table 2** shows, many governors used executive orders to address implementation challenges, the majority of which established health reform steering committees (typically made up of leaders in that governor's administration) tasked with developing initial recommendations or putting together work groups to get stakeholder input. In a small number of states, also included in the table, governors and policymakers took advantage of existing stakeholder engagement processes and workgroups, and simply expanded their purview to include ACA implementation strategies.

States' approaches to decision-making vary and each state's culture has influenced its responses to the passage of the ACA. In some states, decisions are typically made by a few top legislative leaders, the governor, and top advisors. In others, there is a culture of stakeholder engagement and an open and transparent process of decision-making. As a result, the amount of formal and informal engagement with outside stakeholders, the number of meetings to discuss reform implementation, and the public availability of documents and other resources have varied from state to state.

One nearly universal approach to information sharing has been the creation of state websites that include information on implementation efforts or on the ACA more broadly. These sites serve as portals for state stakeholders, and as a repository of resources created by the state. For example, in states that have a history of broad stakeholder involvement, a wide array of resources is available on newly established health reform implementation websites. States with a similarly established stakeholder process and information sharing include, among others, Colorado,[5] Maryland **(see box on page 3.3 for more details)**, Minnesota,[6] Oregon,[7] and Washington.[8]

Other states, including Alabama,[9] Alaska,[10] Illinois,[11] and Michigan,[12] have used their websites to post information about the ACA, along with analyses of the law and implementation timelines.

South Carolina has established a unique policy process. The state is working in collaboration with two organizations—the South Carolina Public Health Institute and South Carolina Healthcare Voices—to engage nonprofit stakeholders to work with state agencies and design an implementation plan for the state. The goal of the effort is to create public-private partnerships that will build on "linkages with key state agencies to support collaborative decision-making and expand the collective capacity to address the

Case Study

MARYLAND

In July 2010, Governor Martin O'Malley established Maryland's Health Care Reform Coordinating Council via Executive Order.[1] The Council is co-chaired by the lieutenant governor and the secretary of the Department of Health and Mental Hygiene. The Governor's Office, the Department of Budget and Management, the Insurance Administration, the Attorney General, the Maryland Health Care Commission, the Health Services Cost Review Commission, the Department of Human Resources, and the State Senate and House of Delegates are all represented on the Council, supporting cross-agency and cross-branch engagement and collaboration.[2]

The Council's Interim Report, issued July 2010, outlines several characteristics that Maryland's ACA implementation must have:

- Serve the overarching goal of improving the health of all Marylanders, with particular focus on health equity.
- Develop a consumer-centric approach to both coverage and care.
- Use the tools provided by reform to improve quality and contain costs.
- Think broadly and creatively about strategies to promote access to affordable coverage and mitigate risk selection.
- Prepare and expand the health care workforce to meet new demands.
- Lead the nation in tapping the full potential of reform to improve health.[3]

The Council has had a series of public meetings since its creation in July, as have each of its more-targeted workgroups—Exchange and Insurance Markets, Entry into Coverage, Education and Outreach, Public Health, Safety Net and Special Populations, Health Care Workforce, and Health Care Delivery System. Each workgroup was tasked with addressing several key questions, which formed the basis of their reports to the full Council. The workgroups have all submitted final reports to the Council, with public input from the meetings contributing to the recommendations within each workgroup report. The Council issued its final report January 10, 2011, which identifies 16 recommendations for how to implement federal reform in Maryland.[4]

In addition to encouraging the public to participate in the various workgroup and Council meetings, Maryland posts all of its meeting information on its health reform website, and encourages individuals to offer their opinion through the site's "Comments and Questions" button, or via email. Additionally, individuals can sign up to receive email updates about the Council's activities. The low barrier to public feedback and the availability of information on the website contribute to a transparent and open process supported by public and stakeholder engagement.

Endnotes

1 Maryland Health Care Reform Coordinating Council. Executive Order 01.01.2010.15. Retrieved November 11, 2010, from www.healthreform.maryland.gov/documents/executiveorder.pdf.
2 Maryland Health Care Reform Coordinating Council. Council Members. Retrieved November 11, 2010, from www.healthreform.maryland.gov/about.html.
3 Maryland Health Care Reform Coordinating Council. *Interim Report*. Retrieved November 11, 2010, from www.healthreform.maryland.gov/documents/100726interimreport.pdf.
4 Maryland Health Care Reform Coordinating Council. *Final Report and Recommendations*. Retrieved January 11, 2011, from www.healthreform.maryland.gov/documents/110110FINALREPORT.pdf.

implementation of this legislation."[13] Several public-private workgroups have been created to examine specific components of the ACA, and all meeting materials and resources are accessible to the public online.

In many states, foundations and nonprofit groups have been highly engaged in the reform process, often performing analyses of the impact of reform on the state. They have also brought together stakeholders through statewide meetings or more informal meetings to inform the policy-development process. For example, in New York, the New York State Health Foundation funded an analysis of the ACA and its impact on the state.[14]

Other states are using internal staff to gather information and develop options. Those states are conducting their own analyses of the ACA and its implications in task forces or through other vehicles and will bring their recommendations to their governors and legislatures. They will then engage in a more public discussion with external stakeholders, who sometimes find it easier to respond to an existing document or white paper rather than to open-ended policy questions.

INTERPLAY OF POLICY AND POLITICAL ENVIRONMENT

Disagreement over the merits of the policies included in the ACA also affects how state governments have reacted to its passage. While some states have embraced federal reform and are moving forward as quickly as possible to determine how best to implement its provisions, other states are opposed to one or several provisions of the law and have taken to the federal courts to challenge its constitutionality. (See *Surveying the Landscape* for more information.)

However, even in those states that have filed suit against the federal government, efforts are still underway to examine the impacts of ACA and plan for its potential implementation. For example, while Virginia is pursuing a lawsuit to strike down key provisions in the federal bill, it is also one of 48 states and the District of Columbia that applied for a federal planning grant providing federal resources to states to help them determine whether to run their own health insurance exchange, partner with other states in a regional exchange, or have the federal government administer their exchange. Virginia state officials plan to use these funds to support a task force that is already meeting to discuss possible implementation of the federal law and to conduct research to support the policy decision-making process that lies ahead for the state. While the resources and goals of each state vary regardless of whether there is full support for implementing the ACA, most are beginning initial discussions about what the new law means for them.

While leadership changes and the uncertainty caused by ongoing litigation threatens to delay state efforts, the short timeline for implementation of the ACA means that states nevertheless need to have strategies in place for implementation. States have until January 1, 2013, to show they have the capacity to implement and operate a health insurance exchange by January 1, 2014. Many important and time-consuming tasks must be completed before those deadlines. (See *Laying the Foundation for State-Based Exchanges* for more information.)

Case Study

COLORADO

In 2010, Colorado had a very open planning and implementation process, focusing a considerable amount of effort on stakeholder and public engagement and establishing a transparent process that allows the public and interested parties to monitor the state's progress. Their health reform website contains a wide range of resources about the ACA and its potential impact on Colorado, as well as meeting announcements and notes, and the latest news updates. An implementation timeline of the ACA is also posted, so the public and other stakeholders can see when different provisions of the law go into effect and how those provisions will impact the state.[1]

Governor Bill Ritter created an Interagency Health Reform Implementation Board and designated an implementation director in April 2010, allowing individuals from across various state agencies impacted by ACA implementation to meet and communicate across agency silos. The Department of Health and Human Services, the Department of Health Care Policy and Financing, the Department of Public Health and the Environment, the Department of Revenue, the Acting State Chief Information Officer, the Director of National Health Reform Implementation, the Department of Personnel and Administration, the Division of Insurance, the Office of State Planning and Budgeting, the Office of the Governor's Policy and Initiatives, and the chief legal counsel for the governor are all represented on the Board.[2] The Board meets on a monthly basis and all meetings are open to the public. Meeting agendas and materials are posted online.

Even as the Governor's Interagency Health Reform Implementation Board moves forward, it is important to note that the independently elected attorney general has joined the case in federal district court in Florida challenging the constitutionality of the individual mandate.

In addition to efforts to coordinate the various government agencies, the state has conducted a series of health insurance exchange public forums across Colorado, seeking input from members of the public as the state begins its work planning for and designing an exchange. All of the information from those meetings is available on the state's website.[3] The state examined the feedback from these engagement sessions and included, in its final report, the following key points about successful exchange implementation that resulted from stakeholder perspectives:

"A successful health insurance exchange will:

- Successfully connect people to stable coverage.
- Organize the marketplace so that consumers and small businesses can find understandable and reliable information about health insurance products.
- Establish certification criteria for participating plans that ensure consumers and small businesses have meaningful choice between high quality, affordable plans.
- Ensure all plans sold in the exchange offer the federally defined essential benefits package.
- Maximize participation in the exchange to create a stable risk pool and minimize adverse selection.
- Enable consumers and small businesses to purchase coverage without assistance and ensure support for consumers and small businesses that want and need assistance navigating the exchange.
- Maximize continuity of coverage and seamless transitions between public and private health coverage.
- Not duplicate the current regulatory functions of the Division of Insurance.
- Include robust data collection mechanisms to support transparency and accountability.
- Operate efficiently and aim to minimize administrative costs."[4]

In addition to the substantive lessons learned over the course of these meetings, the state learned several key process lessons on stakeholder engagement. Lorez Meinhold, director of national health reform implementation, shared some of these lessons at a National Governors Association meeting in September 2010. Those lessons include:

- Having a professional facilitator at meetings gives the process credibility.
- Creating and making publicly available background information before the meeting allows everyone to have the same discussion.
- Figure out what strategies or topics will be addressed at each meeting: have five questions on the agenda (shared before the meeting so people can prepare).
- Do not let the discussion be just about the "volume" in the room; some groups are more organized than others, but that does not necessarily make their viewpoints more valid.
- Thinking about partners is really important to help get the word out and engage people; make sure to be clear about the roles of partner agencies.
- Consider what type of public process you want to create: what audience are you engaging?
- The audience you hope to reach will impact the schedule of the meetings. For example, physicians may not be able to attend meetings during normal business hours because they are seeing patients. Evening or weekend meetings may be the most effective way to engage that group.
- This is a learning process in addition to an engagement process. Meeting attendees will contribute important ideas and viewpoints, so the state needs to be prepared to use that information as appropriate.
- Transparency is very important. It will help build trust along the way with all of the stakeholders.
- Timing is important: when is the legislative session? In order for the public meetings to be meaningful, their timing needs to be such that they can impact the legislative session.

Endnotes

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Case Study

VIRGINIA

Virginia, like Colorado and Maryland, has used a transparent process for the discussion of federal health care reform. Despite the fact that the state elected to sue the federal government over certain provisions in the ACA, in August 2010, Governor Robert McDonnell commissioned a Health Reform Initiative Advisory Council to develop recommendations for a comprehensive strategy to implement health reform in Virginia. The Council, made up of leaders from the state legislature, health care systems, and business, was asked to recommend innovative health care solutions that meet the needs of Virginia's residents. In December 2010, the Council made 28 recommendations to the secretary of health and human resources. The recommendations focused on ways to improve health care delivery, reform the Medicaid program, and provide guidance to the development of a health benefit exchange.[1]

In an effort to encourage input across state agencies, the Department of Medical Assistance Services, the Department of Rehabilitative Services and Department for the Aging, the Bureau of Insurance, the Department of Health, the Department of Behavioral Health and Developmental Services, the Department of Health Professions, the Office of Health Information Technology, and the Department of Human Resources Management are all represented on the Advisory Council.[2]

In addition to the Advisory Council, the Governor also announced six task forces: Medicaid Reform, Insurance Reform, Capacity, Delivery and Payment Reform, Technology, and Purchasers. The task forces all include a wide array of stakeholders, including consumers, and are geared toward taking a broad view of issues. The Advisory Council held three two-day retreats and the six task forces met 18 times, all with the opportunity for public comment. The final report and summary reports from the Advisory Council and task force meetings are available for the public and other interested stakeholders to view on the state's website.[3]

Endnotes

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CONCLUSION

States varied in their approach to the implementation of health reform, but across states, some best practices emerged. These include:

- Establishment of a high profile health reform steering committee to make recommendations to the governor and legislature;
- The use of white papers or other discussion briefs to facilitate input and decision-making;
- Establishment of working groups to study difficult issues;
- Creation of a website with information about public meetings and decision points;
- Use of nonprofit groups and foundations to expand state capacity and facilitate stakeholder involvement;
- Passage of legislation to establish an exchange or to enforce insurance reform provisions; and
- Use of an open and transparent decision-making process.

Going forward, every state will need to establish a decision-making process that brings together key leaders and garners input from affected stakeholders including the general public. Once exchange governance has been decided, states will likely shift some of this work to that entity, whether it is within state government or under the auspices of a new governing board. (See the discussion within the Exchange section for more information about issues related to governing boards.)

States will likely achieve their process goals in different ways. Every state possesses an entity reviewing federal health care reform; Table 2 shows the states that have formed workgroups and committees specifically to plan for ACA implementation. In addition, some states may also be advancing their ACA implementation process through less formal channels. Regardless of the process used, however, the direction of reform in each state is likely to hinge on the political perspectives of those in leadership. 2010 was a year of significant changes in state political leadership; the impact of those changes will be felt in 2011 and beyond.

Table 2: **State Workgroups, Committees, and Task Forces Studying Impact of ACA**

State	Entity	Establishment Mechanism	Responsibilities
California	Health Exchange Executive Board	Senate Bill 900[15] and Assembly Bill 1602[16]	This board coordinates the development of the health exchange and is required to, at a minimum: • Implement procedures for certification, recertification, and decertification of health plans as exchange qualified health plans (per HHS guidelines). • Assign a rating to each qualified health plan offered through the exchange in accordance to HHS criteria. • Implement the crucial elements of the exchange: toll-free hotline, website up to HHS standards, standardized format for presenting health benefits plan options, eligibility informing mechanism (i.e., will inform individuals if they qualify for other forms of government support, such as the Medi-Cal Program).
Colorado	Interagency Health Reform Implementation Board	Executive Order B-2010-006[17]	The implementation board and the designated implementation director will coordinate all health reform efforts.[18] This includes the development of a strategic plan; coordination of state agencies; pursuit of federal and state grants; assuring compliance with federal law; and extensive engagement with stakeholders to assist in the improvement of the health care system in Colorado. Stakeholder activities are facilitated through mechanisms such as the Health Insurance Exchange Forums, which are open to the public.[19]
Connecticut	Health Care Reform Cabinet	Executive Order No. 43[20]	The cabinet consists of commissioners from various state health agencies. They also track reform progress via progress reports.Reports include status of temporary high risk pool, early retiree reinsurance program, rate review, long-term care, etc.[21]
	SustiNet	Public Act-09-148	Originally created in 2009 to establish a framework for comprehensive health reform in Connecticut, the SustiNet Health Partnership Board of Directors was additionally charged with making recommendations on how the provisions of the ACA fit with the SustiNet structure.
Delaware	Delaware Health Care Commission	Title 16, Chapter 99 of the Delaware Code[22]	The commission has been proactive in health care reform in Delaware since 1990, and has tasked itself with issues concerning health care reform since ACA passage. The commission has listed federal health reform implementation as an agenda item at each meeting it held in 2010.
District of Columbia	Mayor's Health Reform Implementation Committee	Established by former D.C. Mayor Adrian M. Fenty[23]	The goal outlined by the committee is to ensure the smooth implementation of the federal health care legislation in the District of Columbia.
Iowa	Iowa Legislative Health Care Coverage Commission	2009 Iowa Acts, S.F. 389	This commission is developing a health care reform strategic plan for Iowa. The commissioner of insurance, along with the commission, will develop a plan for operating an exchange. The commission also met with Department of Human Services and the Department of Public Health to incorporate changes resulting from federal health reform.
Illinois	Illinois Health Reform Implementation Council	Executive Order[24]	The council is responsible for making recommendations to the governor about implementing ACA health reform measures.[25]

Table 2: **State Workgroups, Committees, and Task Forces Studying Impact of ACA** *(Continued)*

State	Entity	Establishment Mechanism	Responsibilities
Maine	Health Reform Implementation Steering Committee	Executive Order to Implement National Health Reform in Maine, April 2010[26]	The Steering Committee is charged with developing plans to implement provisions of health care reform, including high risk pools, the state health exchange, and an overall plan with a timeline for implementation.[27]
	Joint Select Committee on Health Reform Opportunities and Implementation		Composed of 17 legislators appointed by the speaker of the House and the president of the Senate, this Joint Committee was established to study the federal law and determine the role of the state in implementing health reform and how the law will affect current state programs and laws such as MaineCare. [28] The Committee is also responsible for consulting with other stakeholders including the Governor's Office of Health Policy and the Department of Health and Human Services.
Maryland	Health Care Reform Coordinating Council	Executive Order 01.01.2010.07[29]	The council is charged with submitting a comprehensive document with recommendations and implementation strategies by January 2011.
Michigan	Health Insurance Reform Coordinating Council	Executive Order No. 2010-4[30]	The council will identify steps for implementing the ACA in Michigan.[31]
Minnesota	Health Care Reform Task Force	Minnesota State Legislature Session Law[32]	The task force was mandated to produce a report by December 15, 2010, with recommendations for state law, program changes, and implementation.
Mississippi	Health Insurance Exchange Study Committee	Senate Bill 2554	The committee is charged with studying the federal requests related to health insurance exchanges and make implementation recommendations.
Montana	Interim Committee	State Joint Resolution 35	The resolution allows for interim study and research on federal and state efforts related to health care reform and the provision of recommendations for state-level initiatives.
Nebraska	ACA Study Select Committee	Legislative Resolution 467	The resolution allows for a study to research and provide recommendations for implementing federal reform. Report from this committee was due December 31, 2010.
Nevada	Health Care Reform Policy Group and the Health Care Reform Implementation Working group	Created by the Nevada Department of Health and Human Services	These groups are tasked with gauging the impact of the ACA on state health care and Medicaid policies.[33]
New Hampshire	Commission on Health Care Cost Containment	Senate Bill 505 (2010)[34]	The commission is focused on the implementation of health care reform and payment reforms. It will also make recommendations to contain costs and improve quality, while examining the hospital services, ambulatory surgical facilities, and health insurance carriers, making recommendations for changes to the system for health care services financing. The recommendations will coordinate with the ACA.
New Mexico	Health Care Reform leadership team	Executive Order 2010-012[35]	The team is tasked with strategic planning around implementation.[36] They released a roadmap to reform that had been accepted by the former governor.[37]

Table 2: **State Workgroups, Committees, and Task Forces Studying Impact of ACA** *(Continued)*

State	Entity	Establishment Mechanism	Responsibilities
New York	Cabinet to Implement Federal Health Care Reform in New York	Established by former Governor David Paterson on May 13, 2010[38]	The cabinet will make recommendations to the governor on all aspects of health care reform and implementation.[39] The cabinet includes advisory groups that not only advise on policy and implementation, but stakeholder and public engagement.
North Carolina	Health Reform Overall Advisory Committee	Established by the North Carolina Institute of Medicine (NCIOM) [40]	The committee coordinates the efforts of eight health reform workgroups at NCIOM. These efforts include identifying decisions that need to be made to implement health reform and identifying and securing potential funding opportunities.
Ohio	Health Care Coverage and Quality Council and Health Care Reform Stakeholders Forum	Council originally established via Executive Order 2009-03S[41] Put into law via House Bill 1 (2009)[42]	The Ohio Health Care Coverage and Quality Council is part of the Forum. The Council has become the main driving force behind improving coverage, cost, and quality of Ohio's health care system, as well as stakeholder engagement.[43] The Council established an additional task force focused on health benefit exchanges.
Pennsylvania	Commonwealth Health Care Reform Implementation Committee; Commonwealth Health Care Reform Advisory Committee	Executive Order 2010-02[44]	The Implementation Committee will model high-risk pools and exchanges, identify technical assistance needs, prepare a strategic plan for implementation, and identify legislative action to enable full implementation. [45] The Advisory Committee will be briefed on the Implementation Committee's findings, and respond to them with feedback. Additionally, it will identify best practices for the Implementation Committee to review, and advise the Implementation Committee on the commonwealth's high risk pool, health insurance exchange, technological and other improvements needed to implement the obligations of the state under the ACA, and the strategic plan for implementation of the ACA in Pennsylvania.[46]
Tennessee	State Insurance Exchange Technical Advisory Groups	Established by the Tennessee Insurance Exchange Planning Initiative[47]	The two technical advisory groups (Actuarial/Underwriting and Agent/Broker) will provide expertise on specific analytical questions to help in Tennessee's exchange planning process.
Virginia	Virginia Health Reform Initiative Advisory Council	Formed as a part of Virginia Health Reform Initiative by the Virginia Secretary of Health and Human Resources[48]	The council is responsible for managing activities related to federal health care reform, serving as the liaison between governor's office, agencies, and other entities. It will also identify and coordinate to procure grants for mechanisms such as the health insurance exchange, as well as convene stakeholder workgroups, and submit recommendations to the governor.
Washington	Health Care Cabinet	Executive Order 10-01[49]	The cabinet is responsible for providing leadership and accountability for implementation of state and federal health reform. The cabinet was to have submitted a work plan by August 2010.[50]
Wisconsin	Office of Health Care Reform	Executive Order #312[51]	The office is responsible for developing a plan that utilizes national health care reform to update existing Wisconsin programs. It also provides public access to information and assesses insurance market reforms. In addition, this office also developed plans to pursue federal funding for health insurance exchanges.
Wyoming	State Agency Leadership Team on Health Care Reform	Established by former Governor Dave Freudenthal on May 14, 2010.[52]	This team was convened to determine how the federal law affects state programs and the people they serve. The team was required to draft a short-term work plan that sets out necessary considerations and actions through January 1, 2011.

ENDNOTES

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