Policy implementation under stress: How the Affordable Care Act's frontline workers cope with the challenges of public service delivery

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Abstract

Public service delivery in the contemporary American state is becoming increasingly challenging. As the implementation of the Affordable Care Act (ACA) shows, new social policies combine high technological and cognitive demands on citizens and government with budget austerity, decentralization and political polarization. Yet, as we argue in this paper, the ACA also shows how frontline workers cope with these challenges by focusing on improving client experiences and policy outcomes. In particular, we consider how non-governmental social-service professionals, critical to contemporary service delivery, cope with high caseloads, legal rigidity, and a lack of policy knowledge on the part of citizens. Variation in coping techniques is consequential; rationing care to deal with large numbers of high-demand clients may lead to poorer service and citizen dissatisfaction. By contrast, techniques like learning and rule bending may actually improve citizens' experience of policy. To examine patterns of coping in ACA implementation, we present the results of 21 in-depth interviews with navigators, assisters, and Certified Application Counselors in Wisconsin and Minnesota. Across both states, our respondents coped by engaging in instrumental action (learning & collaboration) and rule bending, rather than rationing care, routinizing their work, or rigidly adhering to rules. While these pro-client techniques are both fiscally and organizationally constrained, our interviews reveal that social-service professionals use them even in especially adverse circumstances.

Keywords

Affordable Care Act, Street-level bureaucracy, behavioral public administration, coping, frontline work

Introduction

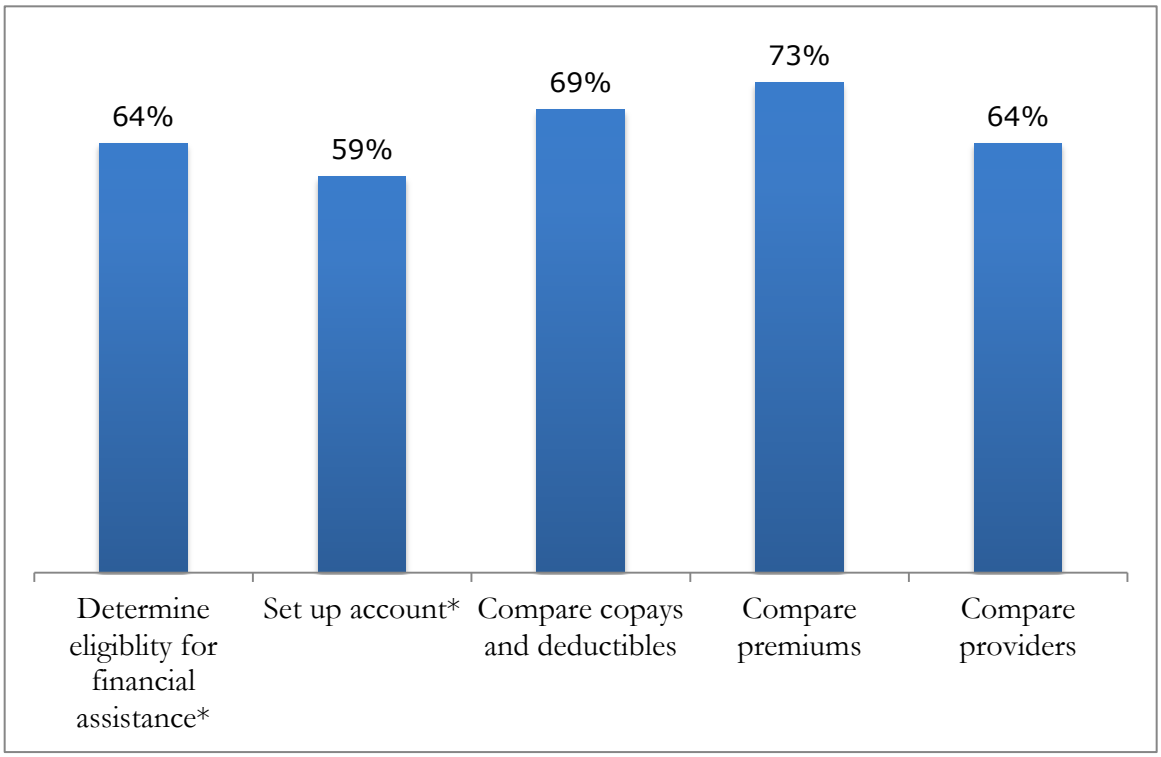
The delivery of public services in the contemporary American state is defined by two contrasting trends. Firstly, service delivery places increasing demands on citizens and the state alike. Federal agencies are expected to provide high quality – hence often costly – service delivery to citizen-consumers. New social policies are also increasingly oriented around individualized, often digital, user experiences and market-style provision (Watkins-Hayes, 2009; Morgan and Campbell, 2011). This shift increases technological demands on government, which must provide high-quality digital benefit delivery without the aid of discretionary street-level personnel (Bovens and Zouridis, 2002; Gilliatt et al., 2000; Tolbert et al., 2008). It also places intense cognitive demands on individual citizen-consumers, who must now comprehend the complex tradeoffs involved in purchasing insurance (Jung, 2010). The second – contrasting – trend is that policies are often politically contested and incremental, resulting in smaller budgets, decentralized policy authority, rigid rules, and extensive public debate (Soss et al., 2011; Oberlander, 2011; Teles, 2012; Moynihan and Herd, 2010).

The early implementation of the Affordable Care Act (ACA) shows that these two trends can make public service delivery especially challenging. On the one hand, the ACA used novel technologies (such as providing online marketplaces) and aimed to provide high quality service to client-consumers. Related to this, the ACA required many citizens who were unfamiliar with the concept of health insurance to make complex and often costly decisions about coverage in an online marketplace (Jost, 2010; Kanchinadim and Jee, 2014). On the other hand, the ACA is very much politically contested, and some states provided far fewer resources to implementing the policy than others, and made it in various ways more difficult to get health insurance (Béland et al., 2014a, b; Cox et al., 2014).

Yet the ACA does not only offer a case study of the *challenges* of service delivery in the contemporary state. In this paper, we examine how frontline workers charged with service delivery have *coped* with challenges. To find these frontline workers in the contemporary U.S., we have to look outside the state, often to nonprofit organizations (Marwell, 2010; Clemens and Guthrie, 2010; Salamon, 2002; Smith and Lipsky, 1993). In the earliest days of the ACA, frontline workers operating outside government—with titles like Navigator and Certified Application Counselor—took on a particularly important role of informing citizens about how they law worked and helping an estimated 10.6 million potential enrollees sign up for coverage (Darnell, 2013; Graves and Swartz, 2013; Kirchhoff, 2013; Andrews et al., 2013; Nadash and Day, 2014; Sommers et al., 2014; Pollitz et al., 2014a). Despite the well-publicized technical glitches in the law, a recent survey of ACA enrollees revealed that majorities found the enrollment process to work smoothly (See Figure 1). Since the ACA's frontline workers have played a critical and understudied role, this paper investigates how they are coping with the challenges of public service delivery, and how their ways of coping influence the implementation of this landmark reform.

Figure 1.

Percent of Surveyed ACA Enrollees Reporting It Was "Easy" or "Very Easy" to…



Asterisk indicates that item N=342 (respondents with exchange plans only). Otherwise N=742 (respondents with plans purchased on exchange and other ACA-compliant plans).

Source: The Kaiser Family Foundation (KFF) Survey of Non-Group Health-Insurance Enrollees, conducted April 3 – May 11, 2014.

Studying how frontline workers cope with service-delivery challenges makes contributions to understanding the ACA, and policy implementation more in general. First, few studies on the ACA have focused on how the role of frontline workers. Many scholars studied the ACA at a more general level, for instance analyzing how the policy has become polarized (Haeder and Weimer, 2013; Béland et al., 2014a). However, street-level bureaucracy and policy implementation literature shows the significance of the behavior of frontline workers in 'making a policy work' (Lipsky, 1980; Tummers, 2011; May, 2003; Gofen, 2014; Maynard-Moody &

Musheno, 2000, 2003). A recent Kaiser Family Foundation report (Pollitz et al., 2014a) did look at frontline workers especially, by analyzing the *challenges* ACA implementers face (see also Darnell, 2013; Andrews et al., 2013; Nadash and Day, 2014). We, on the other hand, aim to understand how these people cope with challenges, as coping behaviors can have important effects on the effectiveness and legitimacy of public policies (Ellis, 2007; Sandford, 2000). For instance, frontline workers might cope with high workload by not following-up on client requests, not calling back clients or not putting in efforts to help them with puzzling requests. This rationing of services can hamper policy effectiveness and can contribute to negative public reactions to the ACA. By contrast, other ways of coping can improve how the ACA functions. For instance, frontline workers can cope with stress by taking instrumental action, learning and adapting to policy problems as they emerge. In this way, they solve problems as they emerge, which improves policy implementation (Maynard-Moody and Musheno, 2003).

To investigate coping behavior among ACA's frontline workers, we will study the coping behavior of frontline workers using the newly developed classification scheme of Tummers et al. (2014). They noted that while coping is an important response to the problems of frontline work, the public administration field lacks a comprehensive classification of coping. Scholars use different terms for the same phenomenon (such as strategies of survival or coping), or use the same terms but define them very differently (compare for instance Newton, 2002; Nielsen, 2006; Satyamurti, 1981). Based on a systematic review of the coping literature (1980-2014) and the recommendations for sound classifications of coping by Skinner et al. (2003), they developed a coherent classification of coping during public service delivery. We are among the first to use this classification to qualitatively study how frontline workers in healthcare cope with policy implementation.

Our analysis relies on state data and documents, and on 21 in-depth interviews with frontline workers in two states: Minnesota and Wisconsin. While both states are nearly identical with respect to relevant demographics (e.g. population race and age, number of eligible uninsured, number in poverty, urban/rural split), they took very different approaches to implementation. Wisconsin defaulted to the federal exchange, forcing frontline workers to rely on small federal grants, and restricted these workers to exclude making recommendations on specific health plans (Kaiser Family Foundation, 2014). Minnesota, by contrast, implemented its own exchange, securing over $4 million dollars in federal funding for frontline workers and spending $8.6 million on outreach in 2013 alone (Stawicki, 2013; Todd-Malmlov 2013). By studying frontline workers in Wisconsin and Minnesota, we can better ensure that our results are robust across states with divergent policy trajectories.

This paper begins by detailing the role of frontline workers under ACA, laying out theoretical expectations about their ways of coping, and describing the study's methodology. Our results show rationing, routinizing, and rigid rule following to be quite uncommon in either Wisconsin or Minnesota. Instead, frontline workers in both contexts reported that they acted instrumentally to solve policy problems—learning and adapting themselves to unforeseen challenges, relying on collaborative networks to develop solutions, and bending rules on behalf of their clients. We conclude by discussing the implications of our findings for the future of client interactions with the ACA, and for policy implementation scholarship more in general.

Frontline workers and the Affordable Care Act

The art of "navigating" public policy for citizens pre-dates the ACA and originated within the walls of hospitals, legal-aid offices, urban non-profits, and community health centers (Folkemer

et al., 2011; Natale-Pereira et al., 2011; Brooks and Kendall, 2012; Darnell, 2013). It is a form of public service delivery focused on helping citizens to get to know the policy content, how to properly engage with the state, and answering questions about potential problems that arise when applying for benefits. Navigating can help facilitate enrollment and increase the use and legitimacy of a new policy. It has also been shown to improve policy literacy more in general (Krasner et al., 2009; Vernon et al., 2007). Recognizing this, the ACA explicitly opted for developing and subsidizing pre-existing service organizations to become 'navigators', 'in-person assisters', and 'certified application counselors' to help connect citizens with either qualified health plans or access to Medicaid. As Table 1 suggests, the majority of organizations engaged in this kind of work under the ACA are non-profit service organizations or Federally Qualified Health Centers (FQHCs) (Pollitz et al., 2014a: 6). Despite their differing job descriptions and funding streams, navigators, in-person assisters, and CACs have all facilitated enrollment under the ACA. Following related literature in policy implementation (Sandfort et al., 1999; Meyers et al., 1998; Harrits and Sommer, 2014; Maynard-Moody and Musheno, 2003), we will term them 'frontline workers': people helping to implement public policies by directly interacting with citizens. These people provide hands-on application assistance and counseling for those seeking coverage, work with communities with special insurance needs such as AIDS patients or the poor, and travel to remote areas to hold informational sessions on the ACA (*Saint Louis Effort for AIDS v. Huff*, 2013).

Table 1.
Composition of Assister Workforce

	Percent of Organizations that Sponsored Assister Program
Non-profit Community Service Organization	38 %
Federally Qualified Health Center	28
Hospital / Health Care Provider	15
State / County / Local Agency	8
For-Profit Business	3
Faith-based Organization	1
Other	7

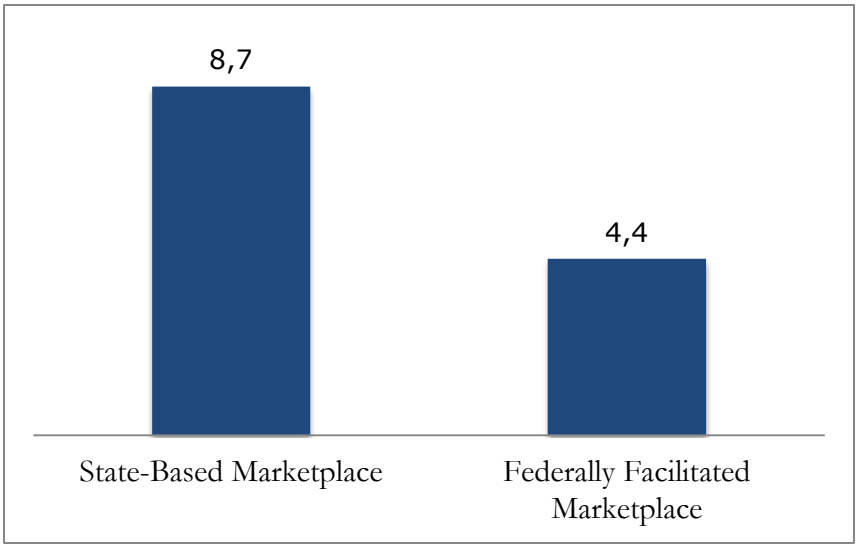
Source: Pollitz et al. (2014a: 6).

Among the challenges frontline workers have faced, two stand out as particularly salient. First, frontline workers were confronted with high work pressure. Although the use of these frontline workers were envisioned before the ACA implementation, they face high work pressure as a result of among else persistent website glitches and the first deadlines for signing up. As Pollitz et al. (2014a, 14) reported: sixty-four percent of assisters in their survey noted that spending one to two hours per client determining eligibility and enrollment assistance; nearly four in ten reported that they could not serve all clients who sought assistance.

Second, many states were confronted with limited resources, especially those which opted for the federally financed marketplace. In these twenty-seven states, frontline workers had fewer resources than in states that implemented their own marketplace (Béland et al., 2014a). For instance in Texas, frontline workers relied on $11 million dollars in grants to help enroll

over 6.4 million uninsured residents (Galewitz, 2013). On the contrary, Maryland, which implemented its own State Based Marketplaces, committed nearly $24 million dollars on client assistance for 700,000 uninsured (Brown, 2013). As Figure 2 suggests, this amounted to huge disparities in human capacity: states with state-based marketplaces, like Maryland (and also Minnesota), had on average 8.7 assisters per 10,000 uninsured residents, whereas states with federally facilitated marketplaces (such as Texas and Wisconsin) had only 4.4 assisters per uninsured on average.

Figure 2
Number of Assister Staff per 10,000 Uninsured, by Marketplace Type (All States)



Source: Pollitz et al. (2014a: 11).

In short, the pressure on the ACA's frontline workers appeared to be substantial, especially during the first open-enrollment period. Yet how should we expect frontline workers to cope with the stresses in their job, such as from high workload? To answer this question, we turn to the literature on coping during public service delivery.

Coping during public service delivery: moving toward or away from clients?

Over the years, policy implementation scholars have analyzed the notion of *coping* within public service delivery. Michael Lipsky (1980) was one of the first to understand the importance of coping in public service work. In a revised edition of this work, Lipsky (2010: xvii) reiterates the importance of coping. He notes that many frontline workers experience stressful working conditions, such as role conflicts and high workloads, and adopt ways of coping to deal with these situations. As policies are nothing but paper until they are delivered to clients (Winter, 2003), Lipsky argues that the ways frontline workers cope when dealing with clients, directly influences public policy, suggesting that the "decisions of street-level bureaucrats, the routines they establish, and the devices they use to cope with uncertainties and work pressure, effectively become the public policies they carry out" (2010:xiii). Examples of coping during public service delivery include rationing services to clients, routinizing work, as well as instrumental action such as learning the policies better to help clients (Dias and Maynard-Moody, 2007; Dubois, 2000).

Tummers et al. (2014) reviewed the work on coping during public service delivery in order to among else define and classify coping during public service delivery. They define coping during public service delivery as behavioral efforts frontline workers employ when interacting with clients, in order to master, tolerate or reduce external and internal demands and conflicts they face on an everyday basis (cf. Folkman and Lazarus, 1980). Hence, coping during public service delivery is behavioral in focus (and not cognitive), and takes places when interacting with clients. Other types of coping can be cognitive, such as wishful thinking, or not taking place when interacting with clients, such as seeking social support from colleagues.

Based on the review of the literature and suggestions for developing sound coping classifications by Skinner et al. (2003), Tummers et al. (2014) developed a classification of families and ways of coping during public service delivery. They identify three families of coping specific to public service delivery: 'moving toward clients', 'moving against clients' and 'moving away from clients'. Moving toward clients, or pragmatically adjusting to client needs, can be seen as coping in the client's benefit. Moving away from clients describes behavioral patterns in which frontline workers avoid meaningful interactions with clients; moving against clients describes frontline workers engaged in direct confrontations with clients. The latter two families can be seen as coping that is *not* in the clients' interest. As we are particularly interested in how coping affects clients, we combine these last two families. Within these families, various ways of coping are specified, such as rule bending for the benefit of the client (classified as "moving toward clients") and rigid rule following (classified as "moving away from/against clients"). Based on the literature, we derived six important ways of coping, which can be classified under the coping families. Under the family of coping 'moving toward clients', we identify rule bending, instrumental action (learning) and instrumental action (collaboration). These can all be in the clients' benefit. Under the family 'moving against/away from clients', possibly used strategies are rationing, routinizing, and rigid rule following. This is shown in Table 2, including the definition and an example for each way of coping.

Table 2
Ways of Coping during Public Service Delivery, including ACA example

Moving toward clients	
Way of coping	***Definition and example***
Rule bending	*Adjusting the rules to meet a client's demands* The MNSure website (an insurance company website in Minnesota) would not approve eligible applicants whose employer-sponsored health-insurance was not technically "affordable" under the law. In these cases, the Respondent instructed the applicants to leave their employer insurance information off the form, which increases their chances of becoming eligible.
Instrumental action – Learning	*Executing long-lasting solutions to overcome stressful situations or meet client's demands, in this case developing knowledge* Respondent developed better training materials than the ones created by the state, which emphasized *knowledge of the law*. If navigators "knew their stuff," she said, they were more able to contest erroneous rulings from MNSure officials.
Instrumental action – Collaboration	*Executing long-lasting solutions to overcome stressful situations or meet client's demands, in this case working with others to solve policy problems.* R: "When we run into problems, we know who to go to…[We are] tied in with a network of other non-profits, and to some extent governmental agencies, but it's just knowing and having a resource list handy and knowing this is a legal aid question, this is the health care access office, it's another non-profit that provides related."
Moving away from or against clients	
Way of coping	***Definition and example***
Rationing	*Decreasing service availability, attractiveness or expectations to clients or client groups* When her caseload expanded to the point that she could not see all of her clients for a given day, the Respondent told her supervisor that providing legal advice to clients was 'above her paygrade' or 'not in her job description' and that she would not do it.
Rigid rule following	*Sticking to rules in an inflexible way that may go against the client's demands* Respondent reported that he really "dove into the rules" and spent hours digesting them at home to ensure that clients did not violate rules in the application, because he was afraid of legal penalties. He ensured that clients filled out tax and insurance information correctly, even if it meant that they would not qualify.
Routinizing	*Dealing with citizens in a standard way, making it a matter of routine* After several months, respondent reported seeing client problems as "all the same," stopped listening to the particulars of their situation, and applied standard "fixes" for problems, such as calling the Healthcare.gov assistance line, without thinking the situation through herself.

Expectations of the coping behavior of ACA's frontline workers

Why would the ACA's frontline workers choose ways of coping that move toward rather than away from clients, or vice versa? The literature gives us two contrasting sets of expectations. First, some scholars suggest that the ACA's frontline workers will cope by moving away from or against clients. The ACA's frontline workers are often working in non-profit organizations, such as the Arizona Association of Community Health Centers and Virginia Poverty Law Center, which work collaboratively with the government to implement health reform, via grants and subsidies (Pollitz et al., 2014a). According to Salamon (1987), nonprofits are often limited by their small size, amateurism and financial insufficiency to address community needs efficiently and effectively (See also Grønbjerg, 2014). Working in such a situation, frontline workers might cope by moving away from clients. Furthermore, measuring the success of the work of frontline workers is often difficult. For instance: how many enrollees should you expect per frontline worker, and which other factors influence this number? Principal-agent models note that when oversight is difficult, agents (here: the frontline workers) will show self-interested behavior and will make their own life as 'easy' as possible, hence rationing and routinizing services (Lafont and Martimort, 2009). Related to this, Delfgaauw and Dur (2008) show that 'lazy' workers will work in the public or non-profit sector when effort is not really verifiable, crowding out the dedicated workers. These studies would thus suggest that frontline workers cope with stress during public service delivery by choosing ways of coping which are not in the interest of clients, but more in their own interest, such as rationing or routinizing.

However, a contrasting view would be that frontline workers do move toward clients when confronted with stress during public service delivery. Feiock and Jang (2009) challenge the argumentation of Salamon (1987). They disagree with the statement that nonprofits are suffering

from amateurism and cannot address community needs. On the contrary, Feiock and Jang note that nonprofit providers are often chosen because they have high professionalism, know the clients they serve well, have connections with other organizations and enjoy legitimacy within the community. For instance, when confronted with challenging work situations, they can reach out to other organizations, thereby learning on the job. Furthermore, many scholars have studied the phenomenon of 'Public Service Motivation' (PSM): "the motivational force that induces individuals to perform meaningful public service" (Brewer and Selden, 1998: 417) (see for instance Perry, 1996; Vandenabeele, 2008). Frontline workers not only work because they like the work (intrinsic motivation) get rewards such as money (extrinsic motivation) but also because they want to provide meaningful services, by among else helping clients (PSM). Especially when they think a particular policy (here: the ACA) is meaningful for their clients or for society, they will show efforts to implement it (Tummers, 2011). Related to this, Dias and Maynard-Moody (2007) found that frontline workers are particularly motivated because they want to help clients achieve long-term success. Based on these studies, we would expect that frontline workers would cope with stress during public service delivery by moving *toward,* instead of away from or against, clients.

To examine whether frontline workers are moving toward or away/against clients, we conducted document analysis and interviews with workers in two states. In the next section, we will describe our study's methodology.

Methodology

Our study focused on frontline workers in two adjacent states, Minnesota and Wisconsin. We chose Minnesota and Wisconsin for several reasons. First, as Table 3 shows, both states have

demographic properties that put them close to national medians (and to each other) on key variables like population, poverty, and non-citizen residents. Second, both Minnesota and Wisconsin have larger per-capita spending and annual household income than the national median for all states, suggesting comparable economic and fiscal climates for public policy.

Table 3. Descriptive Comparison of all US States, Minnesota and Wisconsin on Variables of Interest

	Median (All States)	*Minnesota*	*Wisconsin*
Population	4,315,000	5,314,000	5,661,000
Percent of Population Under 100% Federal Poverty Level	19%	13%	16%
% Non-citizen Residents	5%	4%	3%
Median Annual Income	$50,443	$56,869	$52,574
Per Capita State Spending	$5,740	$5, 920	$7,534
% Vote for Obama in 2012	50.67%	52.65%	45.89%
% Uninsured	14%	10%	17%
% on Medicaid	16%	14%	17%
% Private Employers Offering Coverage to Employees	50.10%	50.10%	49.60%
State-based Marketplace?	N/A	Yes	No
Medicaid Expansion	N/A	Over 138% Federal Poverty Level	Up to 100% Federal Poverty Level
Restrictions on frontline workers' discretion?	N/A	Regulations	Legislation
Assistance Program Capacity	N/A	One assistance program for every **300** uninsured	One assistance program for every **2,650** uninsured

Sources: **Population, poverty, and non-citizen residents**: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements). **Median Annual income:** U.S. Census Bureau, Current Population Survey, 2009 to 2011 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2009-2011 and Two-Year-Average Median Household Income by State: 2010 to 2011, available at

http://www.census.gov/hhes/www/income/data/statemedian/index.html; **State spending:** Kaiser Family Foundation based on National Association of State Budget Officers State Expenditure Report: Examining Fiscal 2010-2012 State Spending, 2012; Table 1 and the U.S. Census Bureau Resident Population Data, 2012. **% of Vote for Obama in 2012:** 2012 Federal Election Commission Report. **% Uninsured and % Medicaid:** Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements**); % Private Employers Offering Coverage:** Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2012 Medical Expenditure Panel Survey - Insurance Component. Table II.A.2. **State-based marketplace and Medicaid Expansion:** Kaiser Health Facts: http://kff.org/state-category/health-reform/. **Restrictions on frontline workers' discretion and program capacity:** authors' calculations.

Most importantly, we chose to compare frontline workers in Minnesota and Wisconsin because the implementation context in these two differs in ways that gives us a large probability of observing *both* families of coping techniques at work in ACA implementation, if that is indeed the case. If we observe only one family of coping behavior in play in both these two contexts, it would allow us to draw a stronger conclusion about patterns of coping behavior among frontline workers implementing the ACA.

The differences across the two states involve the implementation context frontline workers are likely to face. In particular, Minnesota took the path of most states governed by Democrats and established its own state-based marketplace, thereby creating resources for navigators and assisters. On the other hand, Wisconsin defaulted to the federal marketplace, and attracted a much smaller pool of frontline workers, known as Certified Application Counselors (CACs). An indication of this difference is that there is one navigator or assister organization for every 2,600 uninsured persons in Wisconsin, while there is roughly one organization for every 300 persons in Minnesota.[1] Laws in both Minnesota and Wisconsin restricted the kind of advice assisters could give to clients about choosing health plans. Yet whereas Minnesota's restrictions took the form of administrative rules, Wisconsin's legislature sent a strong signal about its

[1] Estimated by the authors based on filings at Healthcare.gov (Wisconsin) and MNSure.com (Minnesota).

willingness to punish assisters by adding to Chapter 628 of its state code on insurance regulations to establish strict licensing procedures on CACs and specifically prohibits them from providing, among other things, "advice about which health benefit plan is better or worse for a particular individual or employer" (Wisconsin Stat. § 628.95; Minnesota Rule Part 7700.0020).

Added to this difference, Wisconsin only partially expanded its low-income health insurance program – BadgerCare – to 100 percent of the Federal Poverty Level whereas Minnesota was one of a small handful of states to expand access to Medicaid *beyond* the 138 percent floor established by the ACA. Concluding, the two states implemented the ACA rather differently. Comparing coping behavior in Minnesota and Wisconsin gives us great potential to examine which sets of theoretical expectations hold up best in both (or either) state.

In order to ensure valid insights, we have used various methods. First, we conducted an extensive document analysis, which included government reports, think tank papers and relevant websites.[2] Second, we conducted semi-structured telephone interviews with 21 respondents, which lasted around 30 minutes each. The first interviews were conducted in January of 2014, during the peak of the first open-enrollment period. Subsequent interviews were conducted as open enrollment wound down, and the last interviews were conducted in June of 2014. We used purposeful sampling (Patton, 2005) to identify 21 frontline workers (10 in Minnesota and 11 in Wisconsin) with experience in assisting applicants for qualified health plans and Medicaid coverage at a range of organizations and contexts. Respondents were recruited until no significantly new insights emerged from subsequent interviews, a process known as data

[2] This analysis included documents the Kaiser Family Foundation, Healthcare.gov, as well as news reports from the states and online posts at State Refor(u)m, an online message board used by frontline workers. In the reference section, all references which have been used for the document analysis are indicated with an asterisk.

saturation. Relatedly Guest et al. (2006) show that data saturation often occurs within the first 6 to 12 interviews. We found that by analyzing the ACA in two states, 21 interviews (10 in Minnesota, 11 in Wisconsin) were needed to achieve this saturation. Thirdly, we checked the validity of our reconstruction by sending the paper to the interviewees (a member check, see Carlson, 2010). Overall, the respondents were in agreement with our interpretation of their experiences.

Table 4. Sample Characteristics

	Wisconsin	*Minnesota*	*All*
Organization Characteristics			
Urban	8	9	17
Rural	3	1	4
Mean Years in Operation	36.27	33.6	35
Non-profit Community Service Organization	3	3	6
Federally Qualified Health Center	7	4	11
For-profit Organization	0	3	3
State/County/Local Government	1	0	1
Interviewee Characteristics			
Male	3 of 11	1 of 10	4 of 21
Mean Years of Experience	9.5	3.5	6.67
Social Work Background	2	3	5
Public Health Background	1	2	3
Lawyer	1	1	2
Bachelor's Degree Only	7	4	11
N=	11	10	21

As Table 4 shows, respondents came from a diverse array of organizations, including non-profit legal-advocacy organizations, FQHCs, as well as for-profit hospitals and clinics. These organizations tended to have long histories of engagement in service delivery, many dating back to the 1960s. Respondents themselves also came from an array of professional backgrounds, from law to social work to public health. On balance, respondents tended to be

earlier in their careers in service delivery, with a slight bias toward more experienced workers in Wisconsin. Additionally, our interviews in Wisconsin tended to come from employees of FQHCs, which is reasonable given that these organizations make up a larger percentage of the workforce in states with federally facilitated marketplaces than those with state-based marketplaces (Pollitz et al., 2014b: 2).

We began our interviews by briefly describing the nature of the project and stressing anonymity. Hereafter, the interviews were conducted using the 'Critical Incident Analysis' technique which is especially suited to analysing coping (Dewe et al., 2010). It entails asking respondents to describe a stressful event (stressor), then to describe how they dealt with this (coping) and the effects (strain). Applied to our research problem, we asked respondents to describe as vividly as possible the most frequent challenges they encountered faced when it came to assisting clients with the ACA. For each challenge respondents identified, we asked follow up questions about how they "coped" with the challenge. Here we used neutral language, asking them: "what did you do to deal with this event?" For each coping behavior, we asked a series of follow-up questions about their techniques, as well as questions about how successful respondents felt their coping techniques were (related to strain), and how often they used each technique. All interviews were anonymized, with pseudonyms assigned (these pseudonyms are also used in the results section), then transcribed as accurately as possible by hand and a journal entry reflecting on each interview was created. We then coded this data to iteratively identify themes and patterns in respondents' challenges and coping behavior (Corbin and Strauss, 2008).

Results

Limited evidence of "moving away from clients"

Our interviews revealed very little evidence of frontline workers coping with stressors by moving away from clients. This finding was surprising to us, and especially so in the case of Wisconsin, where legal- and resource-based constraints on Certified Application Counselors (CACs)—such as limits on their capacity to guide clients to insurance plans—might be expected to be associated with behaviors like the rationing of services and rigid rule following..

Routinizing

Some of the evidence of 'moving away or against clients' we did find was related to the routinizing of work: dealing with unique client problems in a standardized way. As Gina, a navigator in Minnesota told us, the sheer number of clients expanded severely in the final weeks of open enrollment, making it especially difficult to provide what she described as the "level" or "quality" of service that her organization was used to providing. Rationing care was "ethically hard" for her, but she did feel comfortable in routinizing her interactions with applicants—asking them the same questions rather than investigating the unique aspects of their problems. She spent less time building trust with doubtful clients, listening to their stories, phoning them if they missed an appointment, or following up with them after enrollment. By contrast, when volume was low, Gina was able to uniquely tailor her work to client needs, something she felt was essential to the enrollment effort.

Rigid rule following

Only a few navigators reported engaging in rigid rule following, or strictly obeying the letter of the law despite its possible effects on clients. One of the few who did employ this way of coping was Calvin, a CAC in Wisconsin informed us, he often responded to high levels of client demand by rigidly following the rules. For him, state's regulations on frontline workers mattered:

> As a CAC, I am not supposed to recommend [insurance plans] to them, I'm supposed to get them to the stage where, "Here's what plans are available, you pick." And then if they can't pick, say, "Well, you should go and see an insurance agent who can help you understand all these nuances."[…]Everybody I've tried that with, nobody wants to go to an insurance agent. They want me to help them.

Despite these demands, Calvin continued to follow the letter of the law closely, reading regulations to ensure he knew which kinds of information he could dispense and which he could not. As Calvin explains, rigid rule following was not always good for his workflow:

> I don't steer them to any particular plan, but we spend a lot of time looking at the details of each of these plans to help them understand what's available, and all of them, and there's a number of nuances that are very minor, but to some people, it's very important. I mean, some of the plans have an annual vision test, others do not, and you've got to dig into the details of each of these plans to find that and explain, "This has what you want, this one doesn't." Now that takes a lot of time, and you always worry, "Have I missed something?"

What Calvin's interview reveals is that rigid rule following in implementing the ACA is not just about knowing the law and carefully avoiding violations. Instead, rigid rule following can sometimes require additional (sometimes very laborious) work within the boundaries of the law to attend to the needs of clients. Even Calvin, who prided himself on knowing the law, did not accept that the strictures imposed on him were good for clients. Perhaps this is why we found no other instances of rigid rule following as a way of coping in our interviews.

Rationing

We also found limited evidence of rationing. For instance, several navigators we interviewed identified "client overload" during the peak of open enrollment, which placed pressure on them to limit their hours and availability, or even the scope of access they provided to clients. As Amina, a navigator in Minnesota put it, the diversity and complexity of client challenges extended beyond glitches in the state marketplace to clients' own difficulties with English-language comprehension, health and financial problems, and precarious legal statuses. When client volumes expanded, navigators like Amina simply did not always have had the time to effectively translate technical language of health-insurance dominate the clientele, and pose major time challenges for navigators with already staggering caseloads. Client overload led her to ration her attention to problems clients had with state's health-insurance marketplace and to give the state "the benefit of the doubt" and not pursue cases further, at least for a short period of time.

Yet for Amina, as well as the vast majority of our interviewees, rationing was a "last resort" after other coping techniques had failed. As Beza, another navigator in Minnesota told us: "A lot of people can't advocate for themselves" and that she felt it was important to devote as much time as she could to each client, especially in adverse situations. One of Beza's clients was a paraplegic man in an extended care facility who could not show up in person to meet with her. His wife could intervene on his behalf, but she did not speak English. It took the clients over five months to receive coverage, during which time they placed constant phone calls to Beza and visited on a regular basis. Beza's level of involvement with and casework was something that she did not expect, and it profoundly affected her life outside work. She was

working overtime frequently and getting little sleep, yet she did not ration her time with cases. Only recently insured herself, she felt she knew what her client was going through, which gave her the ability to "push through" for him. In addition to identifying with the client, she reported that she knew insurance would make a "huge difference" in his life and the lives of his family (Tummers, 2011; Dias and Maynard-Moody, 2007). In each of our interviews, we found frontline workers "pushing through" on behalf of clients. The next two sections describe those behaviors in greater detail.

Moving toward clients: the role of client-centered organizational expertise

When we began our interviews, it quickly became apparent that the nongovernmental organizations that support ACA enrollment have long histories of client-oriented work. This includes legal-aid organizations that help citizens secure government benefits to community action agencies founded during the Great Society to provide benefits and advocate on behalf of citizens, to FQHCs, which provide comprehensive care to persons of all ages, regardless of their ability to pay. In additional to personal identification with clients and commitment to providing meaningful public services, the ACA's frontline workers operate in an organizational context imprinted with a logic of service delivery in which clients come first (Marwell, 2010; Wright, 2014). We found direct links between this organizational background and the ways of coping instrumental action (learning) and rule bending.

Instrumental action: learning

First, client-oriented organizational expertise helped frontline workers to learn about how to solve client problems, both on the spot during client meetings, and in a more systemic fashion.

Often, we heard frontline workers describing their organizations as having a "health care nerd" culture, in which familiarity with the insurance market and associated regulations was a common source of support when client situations proved unique or unfamiliar. Jeff, a CAC at a rural county hospital in Wisconsin, reported that he relied on his extensive experience with the insurance market to solve the problem of client confusion with the website. When interacting with clients who did not appear to understand the concept of health insurance, Jeff used examples from his 23 years of experience with insurance providers to demonstrate the tradeoffs inherent in alternative plans and the likely benefits of each given a client's medical history. Jeff and his colleagues also developed a long-term strategy to solve this problem, developing instructions for clients to take home and a process for re-scheduling appointments when clients did not feel they were prepared to complete their application.

Other frontline workers used similar behavior to help client in stressful circumstances. Workers in legal-aid organizations, for example, applied knowledge of administrative law to solve problems. Beza, a navigator in Minnesota, found major problems with the state marketplace (MNSure) when she started her position. MNSure was late in developing navigator training materials, and when they finally arrived, they were – in her words - "awful." For instance, virtually no information was present on how to serve non-traditional families (with a grandmother as parent, for instance). Beza coped with these problems by helping to develop training materials—including powerpoints, tip sheets, and guidebooks—that filled in the gaps left by state training materials. If navigators "knew their stuff," Beza said, they would be better able to contest erroneous rulings from MNSure officials.

Rule bending

Second, we discovered that organizational expertise gave frontline workers the capacity to "bend" their interpretations of ACA rules to fit particular client needs. Interestingly, most of our interviewees reported that they did not see bending the rules as even a modest violation of the law. Rather, they suggested that they were "bending the rules back into place." As a number of our interviewees suggested, since state and federal agencies often interpreted statutory guidelines in erroneous ways, it became the job of frontline workers to "know the law" and to ensure that applicants for public services were being treated fairly.

Jim, a CAC at a FQHC in Wisconsin, gave one example of how "bending the rules back into place" works. As Jim discovered, healthcare.gov applications required married applicants to file taxes jointly in order to be eligible for subsidies. Yet, as he told us:

> Something we have a lot of [is] separated couples that haven't lived together for years, wives that don't even know where their husbands are, or even if they are alive…but they're still married. Maybe they never actually got a divorce because expense or time, or something like that.

In these cases, correctly filling out the information would lead to a deprivation of tax-credits that seemed to Jim to be nonsensical and inconsistent with what his organization had hired him to do. As he put it:

> I'm here as a [CAC] because I have a degree in Psychology…I try to make sure that my patients always leave like they're feeling like they've done something productive. So, when [the website] is down, or whatever, I tell my patients, "We have this paper application, and we're gonna fill it up and once the site is back on, I will do the application on my own, and you can just come back to sure plan."…It's a lot better saying, "Oh, you know what? We can't do anything, you're just gonna have to come back later."

When problems like joint filing arose, then, Jim's solution to the problem in this case was to bend the rules to help clients. To do this, he got in touch with federal officials at CMS to ensure that this was an appropriate interpretation of the law. When clients were married but in a situation where filing jointly was impossible, Jim told us that they filled out the application without the correct information: "we put 'no' [on the application], that they are not married, they are just filing as "head of household."

Inter-organizational networks and collaboration

Beyond the organizational context, frontline workers also coped with another form of instrumental action: collaboration. When confronted with challenges, they collaborated with other individuals in inter-organizational networks, made up of peers, representatives from state agencies, and insurance companies. In Wisconsin, the state Department of Health Services worked with community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders to establish 11 Regional Enrollment Networks (RENs) (Wisconsin Department of Health Services, 2014). In Minnesota, the state's marketplace contributed to local implementation efforts like Insure Duluth, a consortium made up of seventeen organizations, representing community non-profit agencies, health care providers, a foundation, faith communities, and higher education (Insure Duluth, 2014). These networks organize both in-person and online interactions. Frontline workers often meet each other in person in the form of "study groups" on particular issues as well as for larger group sessions with state officials and health-insurance professionals. Online, these networks keep frontline workers apprised of rapid changes in regulations and technical fixes. Informally, members of these networks often keep in close contact through shared online documents and spreadsheets.

In both states, inter-organizational networks facilitate kinds of collaborative activity that has become essential to how frontline workers cope to provider better service to clients. We provide examples of how collaboration was used as a coping strategy for both on-the-spot challenges and more long-term problems.

First, networks provide a resource for on-the-spot challenges that workers face with enrollment. When frontline workers are confronted with unfamiliar situations requiring outside expertise, inter-organizational networks can give peer-to-peer advice through face-to-face interaction or lists of "go to" experts. As Calvin, a CAC in Wisconsin, told us:

> There's a navigator group in a county not too far from us that I met at a meeting, and I called that individual a number of times for assistance when I had a question I didn't understand, or how to do something. So, the resources are there, and some people who are [providing assistance to CACs] on a daily basis.

Second, networks provide a means of recognizing broader problems with enrollment and developing systematic solutions that cover broader client populations. Amina, a navigator in Minnesota, reported that regional networks allowed her to pick up tacit knowledge other individuals had from working on particularly challenging issue of enrolling immigrants who lack citizenship status. Recognizing the power of these networks, Amina told me that one way she coped with these challenges was by developing a "manual" she could use when facilitating enrollment for clients who were recent immigrants to the US. This manual, and a presentation based on it, has been distributed informally nationwide.

Barriers to moving toward clients

We found a substantial evidence to suggest that the ACA's frontline workers cope with adverse circumstances by 'moving toward' clients. However, we must state that we also found that the workers' experienced considerable strain from their work, possibly because their coping strategies of 'moving toward clients' was not always beneficial for themselves. Interviewees across state contexts reported a lack of resources and an almost constant pattern of overwork during open enrollment. For instance, we heard reports of an exceptionally talented worker quitting because he simply "couldn't take it anymore."

Respondents also reported that uncertainty about their role under the ACA made it difficult for their organizations to maintain a steady stream of employees. Several told us that frontline worker positions have been cut since the close of open enrollment, and since their functions must be re-appropriated by Congress and state legislatures and re-evaluated by non-profit agencies, the prospects of the navigator program remain somewhat uncertain. This uncertainty is consistent with national trends: the Center for Medicare and Medicaid Services has reported that funding for assisters in states with Federally Facilitated Marketplaces will drop by ten percent next year; few states have provided a clear indication of what their future support for the program will be (Pollitz et al., 2014a: 24). With a more limited workforce and the persistence of post-enrollment problems among applicants, it is possible to imagine additional pressure on frontline workers that would make moving toward clients quite challenging.

Discussion and Conclusion

The central goal of this paper is to understand how frontline workers charged with implementing public policies cope with service delivery challenges, and whether they cope by moving toward clients or away from/against clients. In implementing the Affordable Care Act, frontline workers confronted a policy shot through with challenges, including technical failures, legal rigidity, low resources, and political contestation. Based on the document analysis and especially the interviews, the major conclusion is that frontline workers frequently coped with stress by moving toward clients: interpreting rules in a way that benefited clients, learning on the job to help clients, and collaborating with individuals in other organizations to improve service delivery.

This conclusion challenges the expectation that frontline workers are often moving away from or against clients, as discussed in the theoretical part of the paper (Salamon, 1987; Grønbjerg, 2014, Delfgaauw and Dur, 2008; Lafont and Martimort, 2009). It comports with other studies, such as those on Public Service Motivation (Brewer and Selden, 1998). For instance, we observed workers with a strong commitment to help their clients (see also Dias and Maynard-Moody, Maynard-Moody and Musheno, 2003). Furthermore, in line with studies on policy alienation (Tummers, 2011; 2013), we found that when frontline workers thought that the ACA was meaningful for their clients, they put in efforts to help implement the policy effectively. Furthermore, the interviews revealed that frontline workers were situated in nongovernmental organizations with strong legacies of client-centered activity. Many of these individuals (and their organizations) had long pre-existing ties to their community. As locally situated actors, they use their knowledge of particular social or market challenges clients face to

make adjustments to policy problems based on updated information about how markets and users operate (see also Feiock and Jang, 2009).

In addition to this general point, two additional conclusions can be drawn. First, our findings show that frontline workers are still quite influential to the implementation of a reform that nominally takes "street-level" workers out of the picture in favor of a digital interface. Hence, it does not seem that the ACA implementation has been totally dominated by ICT (becoming a full 'system-level bureaucracy', see Bovens and Zouridis, 2002). Serious technical malfunctions that accompanied the early rollout of the law placed a premium on human contact, which the ACA's frontline workers were expected to satisfy. Coupled with high enrollment volumes, erroneous denials of benefits, and client difficulties with choosing health coverage, the e-government of health reform was dependent on the discretionary activities of frontline workers. Our interviews suggest that the decisions of frontline workers are still critical to the effective implementation of production of e-government reforms (cf. Buffat, 2014).

Lastly, we must note that - while respondents noted that they often coped by moving toward clients - the interviews caution against expectations of voluntary heroism. Survey work by Pollitz et al. (2014a: 14) suggests, 37 percent of frontline workers nationwide reported that demand for assistance outpaced capacity during all of open enrollment. With winnowing federal financing, inconsistent support across state and organizational contexts, the kind of coping techniques we observed may easily give way to more rationing, rigid rule following, and routinization. Future research could analyze whether the results found are also robust over time.

This brings us to the limitations and future research suggestions. First, we must note that the results found could be dependent on the research context (the ACA implementation in two states). It would be interesting to conduct studies using the same theoretical model which focus

on other groups of frontline workers who have other types of professional training or who have to implement quite different policies in different circumstances. Related to this, an interesting venue for research would be to analyze cases that are less IT-driven.

A second limitation is that we used interviews and member checks with frontline workers. The answers they give might be socially desirable, for instance noting that they 'move toward clients' while in fact they often do not. Although we tried to reduce social desirability by stressing anonymity and asking non-leading questions, this cannot be completely eliminated. Future studies could analyze the coping behavior of frontline workers by asking others, such as clients, supervisors or colleagues.

Third, future studies could more systematically analyze coping behavior and its antecedents using a quantitative approach. By quantitatively showing how much frontline use specific ways of coping, it can be statistically shown whether (not) they really move more 'toward' clients. Important antecedents are for instance perceived workload, social support, work experience and organizational membership (Sager et al., 2014; Brodkin, 2011).

To conclude, this paper has shown that frontline workers implementing the ACA cope with stress by assisting clients, even in adverse circumstances. Further research on how and why frontline workers cope with stress during worker-client interactions should prove to be a timely and productive endeavor for both scholars and practitioners alike.

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