Healthcare.gov and State Capacity in the Digital Age

Grahm Tuohy-Gaydos

Leadership Studies, Williams College

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Prof. Williams

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Introduction

There is an array of research which has connected rising distrust in democratic governance with decreasing state capacity and the failure to deliver effective government services. Private contractors now outnumber federal officials nearly two-to-one and government spending on service procurement has risen considerably as the state has become increasingly dependent on the private sector to develop and enhance key services.[1] These efforts have been particularly notable in the digital government arena, where contractors have taken a critical role in modernizing outdated functions and procedures. Not surprisingly, this increased reliance has largely been assumed as necessary, or in the case of digital transformation, even lauded. However, private sector solutions have been at the center of controversy across nearly every sector of procurement, causing massive spending overruns and damage to state reputation in the eyes of citizens.

This research paper will examine one of the most prominent cases of private-public partnership failure in the last 20 years: the 2013 healthcare.gov launch. The website, which served as the centerpiece in the rollout of the Affordable Care Act, was marred by technical difficulties and poor design, which impacted public perception of the law and had long-term policy implications. This raises the question: What does the healthcare.gov rollout reveal about the nature of private-public partnerships, and how did the Obama Administration's flagship digital (and healthcare) policy initiative end up in such circumstances? In what ways was the site's development constrained by structural factors, and do these indicate towards a larger challenge for state capacity more broadly?

[1] Kamarck, Elaine. "Is Government Too Big? Reflections on the Size and Composition of Today's Federal Government." Brookings Institution, October 10, 2016. https://www.brookings.edu/articles/is-government-too-big-reflections-on-the-size-and-composition-of-todays-federal-government/#privatization-744.

To address this research question, this paper will begin by establishing a multi-dimensional framework for analyzing the website's failure, drawing heavily from both prior scholarship on the launch and the project management and e-government literature more broadly. Importantly, this prior analysis has paid little attention to the political-structural ramifications at the core of my analysis. As such, the second section will be devoted to identifying the key causes of the failed rollout and determining specific areas of breakdown. This section is not meant to serve as a summary of the healthcare.gov rollout (there is already extensive literature that catalogues the events which led to failure). Its primary goal will be to understand the causes of the website's mishandled launch, and more importantly, the breakdown in private-public partnerships at the core of the project.

The third section will expand upon the prior findings with the aim of identifying a) if these issues are the product of procedural (meaning non-situational in this instance) challenges, and b) if so, whether these are structural in nature, by which I refer to the specific processes, methodologies, and approaches that may have resulted in these failures. It will also consider the policy impact of the failure, centering on two analytical strands: the resulting issues that the failure posed for Americans citizens, and the government's short- and long-term efforts in the aftermath of the failed launch. The explicit aim of this section is to both measure and illustrate the negative impacts, connect them with the rollout's struggles, and establish a temporal link between the previously developed structural failures and contemporary challenges. While the Administration did make sincere efforts to address and prevent further incidents like the website release, this section will serve to illustrate how structural constraints have remained consistent over time, even as the dimensions of project managements failures in the public sector have changed.

Lastly, the final section will situate the case within the broader crisis of democratic capacity, connecting the key points of failure to a larger crisis of legitimacy and inability to meet common standards and expectations set by policy experts and policymakers. This final section, building off the findings from the primary sourcing, will speak to and synthesize the negative outcomes and structural constrains which contributed to the failure of the healthcare.gov launch. It will also demonstrate the erosion of long-term bureaucratic expertise that has occurred because of these institutional challenges, and how the fragmented, contract-dependent governance model currently in place undermines not only performance, but the legitimacy and durability of state policies themselves.

Importantly, this analysis is *not* focused on the actual contents of the Affordable Care Act (ACA) itself beyond its contributions to the failed launch of the website. While of importance to understanding the launch, this paper is less interested in the policymaking process than in the institutional processes which transform policy into actual outcomes. The only key policy dimension that is of central concern to this analysis is the federal exchange, or as it is integrated into healthcare.gov, the Federally Facilitated Marketplace (FFM). The FFM is one of the central components of the ACA; it is a health insurance exchange operated by the federal government and also serves states that declined to establish their own marketplaces. The FFM provides a regulated marketplace where individuals and small businesses can compare and purchase qualified health plans that meet ACA standards, which are placed on the marketplace by healthcare providers. In simplest terms, the FFM is one of the most technically and legally complicated portions of the Act, and was the critical component that the government needed to implement successfully for the law to be treated as a success.

Section I. Project Management and Literature Review

Given the scope and scale of the healthcare.gov build, it is important to have a strong grasp on the project management literature and prior approaches to analyzing the healthcare.gov incident. With regards to the former, there are an array of approaches which have been developed to assist in e-government failure assessment. Heeks, for example, is mainly focused on design-reality gaps, and develops a framework centered on information, technology, processes, objectives and values, staffing and skills, management systems and structures, and other resources which has been used widely.[2] Coursey and Norris add that many popular e-government models presume a level of institutional capacity and interagency cooperation that rarely exists in practice, and emphasize a focus on the cooperation aspects of the development process.[3] Meanwhile, Chandler and Choi's knowledge based framework is also useful, as it indicates how inter-institutional frustrations can inadvertently decrease effectiveness as staff struggle to adapt to changing technological requirements of their work.[4]

Anthopoulos et al., meanwhile, identify eight *causes* of e-government project failure (design-reality gaps, missing focus, content issues, skill issues, execution issues, regulatory issues, external factors, and missing user satisfaction) and eight *factors* of e-government failure (Organizational power, politics, education, project management issues, ambiguous business needs and unclear vision, security and privacy, finance and operational costs, and ICT and system development process), which they define as, "Forces of failure, which exist before project

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[2] Richard Heeks, "Most eGovernment-for- Development Projects Fail:,", 2003, p. 3.
[3] David Coursey and Donald F. Norris, "Models of E-Government: Are They Correct? An Empirical Assessment," *Public Administration Review* 68, no. 3 (2008): 523–36, https://doi.org/10.1111/j.1540-6210.2008.00888.x, p. 529.
[4] Taehyon Choi and Susan Meyers Chandler, "Knowledge Vacuum: An Organizational Learning Dynamic of How e-Government Innovations Fail," Government Information Quarterly 37, no. 1 (January 2020): 101416, https://doi.org/10.1016/j.giq.2019.101416, p. 4.

conception or remain after project completion in the project ecosystem."[5] I am primarily interested in the latter, but the authors struggle to identify the differences between failures and factors themselves, which complicates their easy-to-use framework.

The above framework, developed by Anthopoulos et al., emerged from an examination of the Healthcare.gov launch, though the broader study that follows is less directly useful. While it effectively identifies key causes of the failed rollout, such as gaps in organizational learning, misalignment between policy and IT, urgency-driven execution, and flawed design, and offers a strong overview of common failure factors in e-government projects, which has been helpful as I begin my primary source work, the actual research does not fully apply these frameworks to the Healthcare.gov case. Instead, it relies on Twitter data to explore public response to e-government failures.[6] The other more relevant work, by Srinivasan, provides a more targeted look at the case, including a detailed breakdown of events and thoughtful consideration of structural issues and the role of public-private partnerships in the platform's failure. However, it ultimately serves mostly as a conceptual and forward-looking piece, offering recommendations for how governments should manage future e-government initiatives.

Given the focus of this analysis, I have adopted an amalgamation of Heeks' and Anthopoulos et al.'s respective frameworks, containing five component arenas:

> *Information.* Comprised of issues emerging from a lack of necessary information to complete a task, or the absence of legal/regulatory clarity given that agencies are also tasked with identifying how to actually implement the laws passed by Congress.

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[5] Leonidas Anthopoulos et al., "Why E-Government Projects Fail? An Analysis of the Healthcare.Gov Website," *Government Information Quarterly* 33, no. 1 (January 2016): 161–73, https://doi.org/10.1016/j.giq.2015.07.003, pp. 163-164.
[6] Anthopoulos et al., 2015, pp. 164-165.

Technology. Failures that relate to a lack of technology, bandwidth, or the physical infrastructure necessary to make a project work.

Objectives and Values. Failures resulting from a lack of focus, ambiguous needs or unclear visions of the project, or from design-reality gaps (what is desired vs. the actual product being produced).

Staffing and Skills. Any issues that are the result of lack of skill or staffing, or the inability to effectively execute a given task because of said challenges. Can also refer to a lack of educated workers, especially for tasks which require highly specialized knowledge.

Management Breakdown. Failures resulting from a breakdown in traditional expectations in project management; poor communication, a harmful work culture, and the lack of clear leadership all fall within this category.

Political Challenges. Any sort of project failure which is the result of a lack of political bandwidth or outright opposition, external pressures from groups both in support of and opposed to certain services, and internal infighting that is a direct result of political pressures (i.e. delays in implementation to assist one party or to harm the image of appointees).

Importantly, three factors fall outside the core areas of emphasis outlined above: a) failures stemming from processes, b) a lack of organizational power, and c) structural challenges. While Heeks and Anthopoulos et al. incorporate these elements into their respective frameworks, they tend to operate around and in conjunction with the other categories. Though some interaction effects exist among the five core causes—for instance, a political shutdown can exacerbate staffing issues—they are generally less pervasive than the ways in which each core cause

interacts with process-related or structural and organizational threats. In reality, the five factors discussed above operate within broader process dynamics and the institutional constraints of government, which impose distinct structural and organizational limitations. As such, this model aims to account for the deeper influence of these surrounding factors within the five primary causes of project failure, rather than treating them as separate or equally weighted sources of breakdown.

Section II. Sources of the *healthcare.gov* Failure

While there were failures in each level of the developmental process for the website, six were of greatest note: the lack of clear leadership and poor contract oversight (management breakdowns); inadequate planning and development (objectives and values failure); mismatched and underprepared staff (staffing and skills); policy system inconsistency (informational breakdown); and politicization (political threats). Each of these is expanded up below.

Lack of Clear Leadership

Throughout the entire development and rollout of Healthcare.gov, the project was consistently marked by a lack of clear leadership at every level. Most notably, there was no designated systems integrator—someone responsible for 'seeing the whole picture' and ensuring the project progressed smoothly despite being developed in fragmented parts. Until the launch, administrators at the Center for Medicare and Medicaid Services (CMS) neither hired for this role nor fully recognized that they themselves were not effectively fulfilling the position.[7] At the same time, CMS failed to establish a clear leadership structure for the project overall. Officials

[7] U.S. Department of Health and Human Services Office of Inspector General, "Marketplace Enrollment: Contract Planning and Procurement" (HHS OIG, 2015), https://oig.hhs.gov/oei/reports/oei-03-14-00230.pdf, p. 10; U.S. Department of Health and Human Services Office of Inspector General, "Case Study of CMS Management of the Federal Marketplace" (HHS OIG, 2016), https://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf, p. 21

were often uncertain about their specific responsibilities and how their roles fit into the broader effort, which further fragmented the development process.[8] This confusion was compounded by the decision to shift oversight of the website's launch from the Office of Consumer Information and Insurance Oversight (OCIIO) to CMS, without clearly delineating responsibilities. As a result, OCIIO was left to onboard CMS and hand off the project midstream, further undermining continuity and coordination.

Meanwhile, similar challenges were seen on the contract management side. The lack of a systems integrator meant that the companies hired by the state, and especially CGI Federal, were uncertain of how each of their tasks would work with the others. As one report noted, "The 33 companies [involved] each had individual tasks to support the implementation of the Federal Marketplace, but there was no single point-of-contact with responsibility for integrating contractors' efforts and communicating the common project goal."[9] At the same time, contractors also had little idea of who to report to. The contract progress monitoring was managed by government task leaders (GTLs) within the Consumer Information and Insurance Systems Group (CIISG), but it was CMS Contracting Officers (CO) in the Office of Acquisition and Grants Management (OAGM) who were actually responsible for administering the contracts in question. To only further complicate matters, COs did not manage the contracts themselves; rather, they appointed Contracting Officer's Representatives (CORs) to monitor the technical elements of the contract. This complicated web of GTLs, COs, and CORs was nearly impossible for companies to navigate given that each actor had overlapping responsibilities, which meant

[8] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 20.
[9] U.S. Department of Health and Human Services Office of Inspector General, 2015, p. 12.

that many, “Received ‘inconsistent direction’ when asking the same question of the GTL, CO, or COR.”[10]

These leadership issues, combined with a lack of clarity at both the top and bottom of the chain of command, intensified inter-organizational frustration, which had no clear outlet or authority figure to manage it. This only compounded existing challenges, as teams became bogged down by overlapping or contradictory directives. The resulting delays increased backlogs and reduced the time available for proper testing, which meant that even the limited leadership in place had no concrete or comprehensive understanding of the site’s condition prior to launch.[11] This deficiency had significant ripple effects on other aspects of the failed rollout and, across most governmental reports, is identified as the primary cause of the failure.

Poor Contract Oversight

While the lack of leadership contributed to poor contractor oversight and illegal contract implementation, it also served to exacerbate other challenges and represented another key contributor to the failed launch. From the beginning, there was limited development of any sort of acquisition strategy, which was further compounded by a lack of interest from technical firms, who were concerned about the risks associated with the project.[12] This was further exacerbated by the type of contracts chosen; the government utilized a cost-plus-fixed-fee (also known as a cost reimbursement) contract with CGI Federal for the FFM, which carried additional risks and could allow companies to effectively raise costs without regard to the actual effectiveness of the work completed. As the Government Accountability Office noted, “While CMS’s use of the

[10] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 14.
[11] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 23.
[12] U.S. Department of Health and Human Services Office of Inspector General, 2015, p. 10; U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 13.

cost-plus-fixed-fee contract type may have been a reasonable choice under the circumstances, the related risks increased the need for oversight."[13]

Unfortunately, this oversight would be lacking throughout the development. In many cases, contract deliverables were not outlined, no performance reviews were completed, and contractors were effectively left to their own designs with few, if any, sort of checks to ensure that the work being completed was of value.[14] This in part led to massive cost increases, but also poor product development, as CGI and other companies heavily relied on model-driven architecture (MDA) that meant that up to 60-70% of the code base was effectively inoperable.[15] Without functioning oversight, such decision-making was commonplace, and meant that the state was paying upwards of 200 million U.S. dollars for work that it was uncertain if effective.[16] This was only further exacerbated by the disjointed leadership structure outlined in the prior section, as the muddled network of reporting meant that the extent of the delays and performance issues were underestimated and simplistic mitigation plans were accepted without second thought.[17]

Inadequate Planning and Development

Throughout the process of developing the FFM, few, if any of those involved with the website meaningfully planned for the website's eventual deployment. Deadlines would oftentimes go by without any sort of repercussions, project managers and staff in many cases had

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[13] U.S. Government Accountability Office, "HealthCare.Gov: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management" (GAO, 2014), https://www.gao.gov/products/gao-14-694, p. 15.
[14] U.S. Department of Health and Human Services Office of Inspector General, 2015, p. 16; U.S. Department of Health and Human Services Office of Inspector General, "CMS Did Not Always Manage and Oversee Contractor Performance for the Federal Marketplace as Required by Federal Requirements and Contract Terms" (HHS OIG, 2015), https://oig.hhs.gov/reports/all/2015/cms-did-not-always-manage-and-oversee-contractor-performance-for-the-federal-marketplace-as-required-by-federal-requirements-and-contract-terms/, p. 8.
[15] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 17.
[16] U.S. Department of Health and Human Services Office of Inspector General, "An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace" (HHS OIG, 2014), https://oig.hhs.gov/oei/reports/oei-03-14-00231.pdf, pp. 7-8.
[17] U.S. Government Accountability Office, 2015, p. 32.

done little in the way of work to determine how the various components of the site would fit together, and key components were still in development throughout.[18] In a particularly notable case, CGI Federal had to choose a database platform for the project and decided to integrate a NoSQL methodology, but had done little in the way of planning for this core component of its contract obligations. When the government eventually chose MarkLogic as its database provider, it failed to even inform CGI Federal, who were concerned with the MarkLogic platform.[19] The result was unsatisfactory for all parties, and the lack of planning and effective communication on the part of both the contractors and the state only further complicated the development of the FFM. These challenges, unfortunately, were often under-considered—"As one CMS official reflected later, there was a sense that 'it is always like this on major projects, with tight deadlines and complex delivery.'"[20]

Mismatched/Underprepared Staff

Another key contributor would be the mismatch between staff preparedness and actual capacity to complete the necessary assignments. Both the public *and* private sector struggled to find the necessary staff to assist with the work being completed, with staff often moved from other divisions to assist with the development, even if they lacked the technical capacity to understand what was occurring.[21] This was further exacerbated by the high turnover in marketplace staff, with nearly two-thirds of high-level positions vacant at some point during development.[22] New staff had little knowledge of the projects they were tasked with, and oftentimes had no technical background or understanding of digital service deployment. The lack

[18] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 23; U.S. Department of Health and Human Services Office of Inspector General, 2016, pp. 27-29.
[19] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 16.
[20] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 30.
[21] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 25.
[22] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 12.

of internal staff with the insight necessary to evaluate outputs meant that CMS was often reliant on its contractors, who as mentioned earlier, were also understaffed. This allowed the rampant failures and shoddy work described in the prior section and decreased effective communication and leadership—as the HHS Inspector General's comprehensive report on the rollout notes, "The high turnover and lack of permanent managers in key positions hindered program and organizational knowledge while making building relationships among management and staff more difficult."[23]

Policy-System Inconsistency

One of the most prominent challenges that went underreported would be the 'policy-system inconsistencies' which stymied the website's development. The passage of the ACA not only required HHS to develop healthcare.gov, but to transform the complex web of legal language and funding guidelines into a set of comprehensible and actionable regulations and policies. Due to the tight timeframe of the website's development, these two processes had to occur in conjunction with one and other. In simpler terms, CMS and its contractors had no idea what the ACA fundamentally was *while it was creating the centerpiece of the Act*.

At every stage of the website's development, policy-system inconsistency would be a considerable challenge. Lax contracting requirements and expectations were in part the result of the fact that CMS had yet to clarify many of the early elements of the ACA, and the CORs and GTLs were themselves uncertain about the policy requirements on core components of the website.[24] At the same time, this also contributed to late-stage changes that meant contractors had to rewrite vast portions of code to fit the new regulatory guidelines that were sent down,

[23] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 13.
[24] U.S. Government Accountability Office, 2014, p. 13.

even in the final days preceding the launch.[25] This was only compounded by a mistaken belief that most states would develop their own marketplace, which would have taken weight of the back of the CMS, but most states would choose to use the federal system instead.[26] Together, challenges like these meant that the website was often generalized, inconsistent, and structured utilizing competing frameworks and interpretations of the ACA, creating significant downstream effects in the process.

Politicization

Lastly, politicization would be a key issue with the website's development. Internally, the website's status as the 'premier' component of the ACA meant that the Administration was highly keen on the bill and interfered heavily, often to the detriment of the staff involved.[27] As one official stated, "This was the President's achievement. It raised the stakes. It meant that people at my level had a lot of bosses."[28] Will this would be useful later when the website failed, this political pressure often served as a detriment to open communication or effective decision-making. Even as high-ranking officials became increasingly aware of the sheer extent of issues with the FFM and the site more broadly, "It was never a matter of whether we moved forward,"[29]—rather, it was a political necessity given the reputational importance of the ACA to the Obama Administration and its vision for the United States.

This politicization was not only internal—there were high levels of external politicization as well. The ACA was caught in an array of legal cases launched by those opposed to the Act, which hampered positive movement on many policy complexities and slowed development to a

[25] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 16.
[26] U.S. Government Accountability Office, 2014, p. 21.
[27] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 11.
[28] Anonymous official qtd. in U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 12.
[29] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 28.

halt.[30] In this context it faced significant pressure from Republicans, who were heavily opposed to the bill in any form. The most egregious example of politicization would occur on the day of the launch, however, when the government was shut down entirely by the Republican Party.[31] The shutdown would bring the CMS to its knees, with only a tenth of staff working in the key hours and days following the failed launch, only further contributing to and exacerbating the website's issues. Federal contractors, all of whom were still able to work, had no contacts and were tasked with trying to fix the website on their own while HHS scrambled to get the few staff left to work with the biggest contractors to increase the site's useability. The incident serves as a clear example of this external politicization, with the most extreme effects and profoundly negative outcomes that could have resulted in this instance.

Section III. A Structural Construction of the healthcare.gov Failure

Each of the above nexuses of failure can be understood as both a) independent of one another and b) not structural in origin—flawed leadership and a range of project management breakdowns may well be to blame, and under more capable direction, the website's launch might have succeeded. That said, a closer look at the six factors outlined in the previous section quickly points to deeper systemic challenges.

To focus on just one example, a major contributor to the lack of clear leadership and consistent turnover at the CMS was *the regulations on the CMS itself.* A majority of the high-level administrative positions where mandated as year-long contracts under federal requirements, which stymied continuity and encouraged staff to 'cycle through' work on the website.[32] These same requirements decreased CMS's organizational capacity, and the constant influx of new

[30] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 15.
[31] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 34.
[32] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 12.

staff requiring onboarding meant that it could not effectively oversee contractor performance. Such circumstances are peppered throughout the entirety of the buildup and eventual launch of the website. Considerable overlap in positional prerogatives between oversight staff, review boards, and policymakers is similarly not the result individual decision-making failures, but of a systematic construction of government in which good intentions have produced a system in which three individuals can fill the same position under different names and no clarity on where the jurisdiction of one ends and the next begins.

This is largely due to the current model for federal service development, which enforces a component-driven approach that devalues the final product itself. Contractors are assigned narrowly defined tasks, but no one within the state envisions the end product beyond these disjointed components. While reliance on external vendors was a major factor that worsened the Healthcare.gov rollout, it also reflects a deeper issue: a fundamental lack of institutional knowledge within government on how to develop complex digital systems. Interestingly, CMS staff remained proud of Healthcare.gov, even as the site's failures became a national crisis.[33] Officials took great pride in having translated the ACA into an operational program but failed to recognize that the site's disastrous launch significantly undercut the real-world impact of the policies they had worked so hard to implement.

At the same time, the six causes outlined above also illustrate how the structure of the state necessarily disconnects policy, technical, legal, and procurement functions. While clearer governance structures certainly would have helped, little would have prevented indecision due to politicization of the deployment process, late-stage changes to align with newly development components of the ACA, and technical realities. The institutional design of HHS means that

[33] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 44.

these roles are *necessarily* separated—policymakers have no role in project development, the technical directors play no role in interpreting policy, and procurement officials have no control over either. A systems integrator surely would have helped (and did during the rebuild), but decision making wasn't simply fragmented, it was non-integrative by design.

This is in large part because the U.S. state is not built for digital development. The procurement and oversight frameworks used by the federal government and many state agencies was built for fixed-scope, static projects, like buildings and roads. The agile methodologies required to produce digital systems far outscales and clashes with this rigid structure. Bugs and security failures are constant and expected, work is often iterative and unclear until testing occurs, and project oversight requirements may not necessarily align with the actual way services are designed. This model worked when all service deployment was in-house, but the federal government lacks the capacity to develop meaningful digital services, which thereby necessitates outsourcing which requires effective oversight. Unfortunately, the procurement frameworks that the state utilized in the case of healthcare.gov were antiquated, and both served to empower abuse by contractors while constraining their intentions when they were good.

The structural foundations of the failure become abundantly clear when considering the aftermath of the launch. Leadership was overhauled, regulations and contract requirements were set aside or ignored, and the sole focus of the state was to fix the website. Any of the previous roadblocks that hampered the process were to be removed or mitigated.[34] By the second enrolment period, the project would largely be back on track, but the government would expend nearly $2 billion in additional funds to fix the website and CMS required substantive restructuring to be able to effectively administer the site.[35]

[34] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 34.
[35] U.S. Department of Health and Human Services Office of Inspector General, 2016, p. 43, pp. 52-53.

In response to the failed launch, the White House would create the U.S. Digital Service, "[A] small team of America's best digital experts . . . [to work with] other government agencies to make websites more consumer friendly, to identify and fix problems, and to help upgrade the government's technology infrastructure."[36] The team would effectively serve as an 'in-house systems integrator' to assist the state with adopting agile development methodologies and provide assistance on highly technical projects where departments lacked the necessary knowledge base and capacity to develop and deploy digital services. The group was purpose-made to, "[break through] overly rigid interpretations of federal acquisition rules that complicates the government's ability to adopt smarter ways of acquiring high-quality digital services."[37] Unfortunately, it was reconstituted in 2025 as the Department of Governmental Efficiency and its core mission was changed thereby eliminating this critical role going forward.

Section IV. State Capacity in a Digital Age

Nearly 12 years after the failed launch, the federal government continues to struggle with digital services deployment. One recent example was how the U.S. was heavily reliant on physical vaccine passports during the COVID-19 pandemic as its peers quickly developed effective digital tools which eased integration troubles and made vaccine tracking an ease.[38] Meanwhile, the Broadband Equity, Access, and Deployment (BEAD) program, a key component of the Biden Infrastructure Bill, utilized such a complicated awards process that only three states

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[36] The White House, "Fact Sheet: Improving and Simplifying Digital Services," 2014, https://obamawhitehouse.archives.gov/the-press-office/2014/08/11/fact-sheet-improving-and-simplifying-digital-services.
[37] The White House, 2014.
[38] David Ingram, "A National Covid Vaccine Card Has Quietly Emerged," 2022, https://www.nbcnews.com/tech/tech-news/national-covid-vaccine-card-quietly-emerged-rcna11678; David Ingram, "Paper Beats App: Vaccine Verification Will Likely Be Proven Offline," 2020, https://www.nbcnews.com/tech/tech-news/paper-beats-app-vaccine-verification-will-likely-be-proven-offline-n1250569.

have made it to the final proposal stage—much less to even begin to develop the broadband in capabilities desired.[39]

The problem is not simply that these problems continue to exist; service delivery is complex. Rather, the challenge is that the fragmented, contract-dependent governance model of the state and the failures it has produced has wholly undermined the legitimacy and durability of state policies themselves. State capacity is a function of technical expertise, authority, and integration, and when it fails in one dimension, outside actors will step in. In the case of BEAD, the project will likely be shuttered in place of Musk's StarLink, increasing that company's power and authority relative to the federal government.[40] Cases like these are obviously embarrassing for the agencies involved, but they also further reinforce a narrative that the private sector is alone capable of solving Americans problems. Currently, the state is not only ceding technical expertise to the private sector, but its authority and role as integrator and overseer.

The effective delivery of governmental services is essential for democratic legitimacy. For citizens to have trust in government, they need to know that it is working for them. The end of the 'Obama Coalition' can very well be traced to the failed promise of healthcare.gov, and the administration took a substantial hit to its political influence in the aftermath of the deployment.[41] The failed launch holds so firm in the minds of many that even today, healthcare.gov serves as common parlance for failed government capacity, even as millions

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[39] Wes Davis, "Federal Rural Broadband Program Loses Head," *The Verge*, March 16, 2025, https://www.theverge.com/news/630954/rural-broadband-equity-program-head-leaves-trump-musk-starlink.

[40] Julian Mark, "Rural Internet Program on Hold as Musk's Satellites Get New Consideration," *The Washington Post*, April 1, 2025, https://www.washingtonpost.com/technology/2025/04/01/rural-broadband-satellites-starlink-kuiper/.

[41] Alter, Jonathan. "Failure to Launch; How Obama Fumbled HeathCare.Gov." Foreign Affairs 93, no. 2 (2014): [i]-50, p. 40; Benoit, William L. "President Barack Obama's Image Repair on HealthCare.Gov." Public Relations Review 40, no. 5 (December 1, 2014): 733–38. https://doi.org/10.1016/j.pubrev.2014.07.003.

continue to rely on it to get access to health insurance. The ghosts of the website remain, continuing to affect popular perceptions of the state's capacity to build. Healthcare.gov isn't an anomaly, but rather it's the paradigm on which all other projects are assessed.

Conclusion

This paper has demonstrated how the failed launch of the healthcare.gov website serves as a clear manifestation of deeper structural constraints that plague the contemporary American state. The website's catastrophic launch was not merely the result of poor execution or inadequate oversight, but rather the inevitable outcome of a fragmented, contract-dependent governance model that fundamentally disconnects policy development from technical implementation. As such, the healthcare.gov failure serves as a window into broader questions about democratic legitimacy and state capacity in an era where effective service delivery increasingly depends on digital infrastructure.

The first section established synthesized prior frameworks from Heeks and Anthopoulos et al. to develop a multi-dimensional approach that accounts for information gaps, technological challenges, unclear objectives, staffing problems, management breakdowns, and political pressures—while recognizing that these factors operate within broader structural constraints that shape their manifestation and interaction. The second section examined the six primary causes of failure in the case of healthcare.gov. These included the lack of clear leadership, poor contract oversight, inadequate planning, mismatched staffing, policy-system inconsistencies, and politicization, and revealed how each breakdown was interconnected and mutually reinforcing.

The third section then expanded upon these failures, examining how they reflect deeper institutional constraints. Federal regulations that mandate year-long contracts undermined continuity, procurement frameworks designed for static projects clashed with agile digital

development needs, and the necessary separation of policy, technical, and procurement functions created insurmountable coordination challenges. The aftermath of the launch which required nearly $2 billion in corrections and the creation of entirely new institutional mechanisms like the U.S. Digital Service, demonstrated that success required circumventing, rather than working within, existing governmental structures. The final section situated these findings within the broader crisis of democratic capacity, showing how the healthcare.gov failure was not an anomaly, but part of a pattern that continues to undermine state legitimacy. From the COVID-19 response tools to broadband deployment programs, the federal government's inability to deliver effective digital services has consistently ceded authority to private actors while reinforcing narratives about governmental incompetence. This erosion of state capacity has produced a cycle in which citizens lose faith in government's ability to solve problems, further justifying the very privatization that created the dysfunction in the first place.

HealthCare.gov is not just about a website failure—it is a case study in the demands of digital statecraft. Increasingly, governments do not just regulate markets—they build them, and the infrastructure they rely on is digital. The current model treats complex policy implementation as a procurement problem rather than an institutional capacity challenge, leading to repeated failures that damage both governmental effectiveness and democratic legitimacy. Nearly twelve years later, the same structural constraints that led to the bungled healthcare.gov rollout continue to plague federal service delivery The challenge the state now faces is how it will adapt as service delivery becomes increasingly complex. Will it strip itself for parts, as DOGE is now doing, or will it work to upgrade its capacity and ensure it is able to fully deliver on behalf of the American people? The real crisis isn't technical delivery—its institutional. Our task is to determine if we are simply content with more of the same, or if we can labor to increase state

capacity and confront the structural factors that have left the federal government incapable of delivering on behalf of normal Americans.

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