



**THE NELSON A.
ROCKEFELLER
INSTITUTE
OF GOVERNMENT**

State University of New York
411 State Street
Albany, New York 12203
(518) 443-5522
www.rockinst.org

Carl Hayden
Chair, Board of Overseers

Thomas Gais
Director

Robert Bullock
Deputy Director for
Operations

Patricia Strach
Deputy Director for Research

Michael Cooper
Director of Publications

Michele Charbonneau
Staff Assistant for
Publications



Nancy L. Zimpher
Chancellor

ROCKEFELLER BRIEF

UNDERSTANDING HEALTH REFORM IMPLEMENTATION FROM THE GROUND UP

Richard P. Nathan

July 2016

Introduction

In this essay, Richard P. Nathan reviews several issues affecting the implementation of the Patient Protection and Affordable Care Act of 2010 (commonly known as ACA). It's no surprise that there are many implementation questions for an act still only in its third year of full operation. But there are reasons to believe that the ACA will always be a "work in progress." A central truth about the ACA is that its successful implementation depends on the actions of many people and organizations over which the federal government has limited authority. The Supreme Court's decision in 2012 made this point emphatically with respect to states' decisions to expand (or not expand) Medicaid. Yet the ACA not only relies on the decisions of governors and state legislators; it is also affected by the many choices made by insurance companies, consumers, employers, health care providers, multiple state agencies, and others to work. And though the federal government has some leverage over all of these players, the latter respond to many other, often changing variables and interpretations of their responsibilities.

States are in the middle of this complex system and its flux, and they will surely make many new decisions and revisions so long as the ACA exists. For that reason, the ACA Implementation Research Network — a joint program of the Brookings Institute and the Rockefeller Institute — is especially valuable because of its persistent presence in and deep connections within states. Our field research teams are following new developments on the ground, and they can put recent changes in their longer-term context and assess their real significance. The Rockefeller Institute thanks Senior Fellow Dick Nathan and his partner in leadership of the Network, Alice Rivlin, for establishing the project and applying it to key questions about exchange participation and competitiveness, consumer assistance and navigation, and other emerging issues.



Thomas L. Gais
Director
The Nelson A Rockefeller
Institute of Government
State University of New York

Implementation is the short suit of American government, yet we ignore it at our peril. Hardly any law of consequence for American social policy is all sewed up when it is signed. The Affordable Care Act of 2010 is a sure-fire demonstration of why deeper and long analysis is needed of what happens to laws after they are made.

Beginning in 2010, the Rockefeller Institute formed a Network of field researchers — indigenous health policy and public management experts — to study what is happening in-depth, on-the-ground under the new law. With assistance from the Fels Institute of Government at the University of Pennsylvania and later partnering with the Brookings Institution, the Rockefeller Institute recruited experts in forty states to study decisions made, actions taken, and their effects. To date, the Institute has published thirty reports online (twenty-six individual-state reports) about this research. Management of the Network is based at the Brookings Institution.

The Affordable Care Act (ACA) can be thought of as the last big piece, fifty years in the making, of America's patchwork, typically incremental social safety net. Historically, the safety net has favored the elderly and children. Hence, it is not a surprise that this long-awaited addition to the safety net has had as the major group of new beneficiaries working-aged, middle-income adults eligible for income-tested subsidized health-insurance coverage.

For people in the lowest-income group, the law made them newly eligible for Medicaid, which it expanded. Up until this time, working-aged adults without children either weren't eligible for Medicaid or, if they were, their coverage tended to be limited to the very poor.

The ACA, as often true in the past for social policy breakthroughs, was enacted early in the Obama presidency with the momentum of a new start. Also typically, the law was cobbled together out of long advocated ideas about how to expand health-care. There was no time (there rarely is) to ask questions about how workable the law would be.

Finally, after protracted legislative bargaining and last minute jockeying with interest groups and the urgency of action (Senator Ted Kennedy had just died and his successor was a conservative Republican), it was ready for the president's signature roughly a year after his inauguration.

In the back and forth in Congress between the House's liberal view and the Senate's more cautious leaders, the question of who was in charge was finessed. The House favored national leadership; the Senate emphasized the role of state governments to administer the new law. In any event, the law was unclear, as later developments and court challenges would demonstrate, as to who was in charge.

And to top this all off, the decision was made to delay the start of implementation by four years in order to squeeze down the cost estimate of the Congressional Budget Office.

Surprises

In 2014, when work got underway to implement the law, to the surprise of many observers, most states opted out of managing the new health-insurance marketplaces that the law established. Moreover, both the dozen states (mostly liberal states) that chose to run their own exchanges and the federal agency in charge of exchange operations in other states found when they opened up for business in the fall of 2014 that the presumably mechanical role of operating online health-insurance marketplaces with user-friendly computer technology didn't happen smoothly. Glitches abounded, actually more than that – outright systems' failures occurred in many places. It took a full year for the dust to settle and for reasonable levels of systems functionality to be achieved.

But that didn't mean there was clear sailing. The story of how the law works can't be fully understood from Washington. Out in the country, two more surprises occurred affecting the Medicaid program, one attributable to the courts.

On June 28, 2012, when the U.S. Supreme Court deemed the insurance mandate in the law to be constitutional, at the same time it voided the requirement that Medicaid be expanded in all states. The Court said this is voluntary. States "must have a genuine choice whether to accept the offer." The result – nineteen states by current count did not to accept, or at least they haven't yet.

The second Medicaid surprise is that despite the Supreme Court's ruling, new Medicaid enrollments have appreciably exceeded Congressional Budget Office projections. The groundswell of publicity about the ACA had "a discovery effect." People checking on what the law meant for them found they are eligible for Medicaid – and, moreover, that these benefits were relatively easy to access through the ACA individual health-insurance exchanges.

Viewing Change From the Ground Up

Each state is divided into rating areas for purposes of making coverage available to people newly eligible for benefits. In each rating area, health-care plans called "Qualified Health Plans" (QHPs in government argot) are offered to eligible recipients. Citizens are required to sign up.

ACA health-insurance exchanges in each state are responsible for sorting out who is eligible for subsidized insurance and who is eligible for Medicaid. In the latter case, the state is required to enroll them. This applies both in the thirty-two states that expanded Medicaid as the law prescribed and also in states that didn't take the offer to expand. But even in states that didn't expand Medicaid, the new exchanges found they had to deal with the widespread publicity about health reform that produced what are called "out-of-the-woodwork" or "welcome mat" effects. That is, increased Medicaid

participation by people who, as it turned out, were already eligible.

Pity the poor consumers figuring all this out, especially if they don't have a computer, aren't computer literate, know little about how health insurance works, have a limited and/or unstable income, or have life situations that are constantly changing.

Both health insurance and the new law are exceedingly complicated. Consumers need help to make wise choices. Consumer assistance is an important part of the ACA organizational landscape. This involves the role of public agencies, nonprofit groups, and tens of thousands of individuals called "navigators" or consumer assisters, as well as insurance brokers who help consumers enroll for coverage and retain their coverage over time. That last point, retention, is a huge challenge. As many as a quarter of enrollees in many places either pull out or fall out of coverage.

Looking at all of this now, it is amazing to us that we have gotten so far.

Form Follows Function: The Changed Role of Health Insurance Companies

Insurance companies are playing a new role under the ACA. This is a fundamental institutional change. Insurance companies are intermediaries now. They are market makers. They can't turn applicants down on the basis of existing or previous health conditions or set lifetime limits on benefits; they now compete with each other based on the consumer value of their products.

There are basically two ways to think about the transformation in the role of insurers. Health care advocates worry about the plans they offer being too narrow and exclusive. This issue – narrow networks – plays out locally in debates about hospitals and physicians that are not included as providers in "Qualified Health Plans" (QHPs). On the other hand, supporters and many administrators of the law view the resulting competition among insurers as a plus. They see narrowed networks as a tool to negotiate better prices with providers on behalf of the customers, holding down the perennially rising costs of health care.

Managing Competition in ACA Exchanges

Provider networks bundling year-long health services in capitated systems are well-known in the health field as Health Maintenance Organizations (HMOs). HMOs became prominent in the 1970s under a Nixon law encouraging their development. They hit their stride in the mid-1980s, expanding and becoming increasingly commercialized. But they were seen by many health-care advocates and patients as limiting services and making them hard to access. As a result, they faced competition from Preferred Provider Organizations (PPOs) with broader, more flexible networks of providers.

Now, however, without fanfare, managed competition under the Affordable Care Act is increasingly taking the earlier form of negotiated, bundled capitated networks. Most plans were PPOs in the initial years of ACA exchanges, but this is changing in favor of narrower, more tightly defined HMO plans.

In research that the Brookings-Rockefeller Network conducted with the RAND Corporation in 2015 for the federal government in six states on competition among insurer companies and plans (QHPs), we found there were many plans and that the number of plans increased from the first year to the second year under the law.

Will this situation prevail as we move now into the fourth-year enrollment period on November 1st? The decision announced in May 2016 by United Healthcare to suspend operations in ACA exchanges in thirty states, and shortly thereafter a statement from the Blue Cross and Blue Shield Association warning of higher rates in 2017, have focused a laser beam on these local marketplaces. Will they work as intended?

Implications for American Government

Although, historically, insurance supervision has been a state function, this is changing. Now, it is increasingly a shared federal-state function, which is common practice in American federalism. States define “essential” services under the act within broad categories. They are responsible for defining individual health-insurance rating areas, certifying QHPs, and assuring the “adequacy” of their provider networks. States oversee and supervise insurance companies and insurance brokers and are supposed to review and, if judged appropriate, revise health insurance pricing. They are responsible for defining the role and certifying navigators and consumer assisters, sometimes licensing them and in some states charging fees for them to operate.

In short, implementation of the Affordable Care Act is a gigantic public management work-in-progress. There are unanswered questions or, it is fair to say, questions on which only preliminary knowledge is available: What works, where, and

Note

For additional information on the ACA Implementation Research Network, go to <http://www.rockinst.org/ACA/>. The individual state reports that have been completed can be accessed by clicking on the appropriate state on the map shown there. Also, RAND and the Brookings Institution have issued an “Early Assessment of Competition in the Health Insurance Marketplace” at <http://www.brookings.edu/research/papers/2016/01/19-early-assessment-health-insurance-morrisey-rivlin-nathan-brandt>.

why? The focus of the Brookings-Rockefeller Network is on what's happening inside the box at the state and local levels. For example, we are particularly interested now in studying local health-care systems on the ground in places where enrollment is relatively high and stable, prices are judged to be affordable, where Medicaid is smoothly linked to the exchanges, where consumers are being aided, and where the new coverage being offered is considered adequate and fair. There is a lot to learn. New laws like this take a long time to play out.

About the Author and The Nelson A. Rockefeller Institute of Government

Richard Nathan formerly served as director of the Rockefeller Institute and distinguished professor of political science and public policy at the State University of New York at Albany, and is currently a senior fellow and project co-director of the ACA Implementation Research Network at the Institute. Dr. Nathan has written and edited books on the implementation of domestic public programs in the United States and on American federalism. Prior to coming to Albany, he was a professor at Princeton University. He served in the federal government as assistant director of the U.S. Office of Management and Budget, deputy undersecretary for welfare reform of the U.S. Department of Health Education and Welfare, and director of domestic policy for the National Advisory Commission on Civil Disorders (The Kerner Commission).

The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the sixty-four-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.